

Becoming an Ex-Forensic Psychiatric Client:
Transitioning to Recovery within the Community

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ABSTRACT

This study used Constructivist Grounded Theory to explore both how clients within a forensic psychiatric service in Aotearoa/New Zealand transitioned to living in the community and what factors influenced this transition. The method involved six client participants, aged between their late 20s and mid-40s and eight staff participants aged mid-20s to late 50s completing a total of nineteen semi-structured intensive interviews and five walking interviews. A notable feature of the client participants' accounts was their poverty of speech. The staff participants augmented and triangulated the client participants' rich but abbreviated stories. Together, the clients and staff provide insights into the non-linear return of autonomy, which eventually leads to recovery within the wider community. Two major themes developed. First, the transition process was controlled by an elaborate rule-bound apparatus, which was dictated by the label of Special Patient. A second theme revealed how those clients transitioning strived to regain their autonomy during this often-turbulent process. Transition to the community was dependent upon several wellness factors: how they viewed themselves and if they found acceptance in the community. Three distinct stages emerged within a successful transition: 1) Being Well, 2) Becoming an Ex, and 3) Belonging in the Community. The key to facilitating success was the engagement in activities that developed new identities or changed roles by connecting to the community. Making connections took focused and concerted work by the client, and the staff, allowing the client to make conscious choices about their future, to look at who they would like to be and to engage with others for the success of the transition. Ironically, a limitation of the study was the poverty of the client's speech, but that is the challenge of this particular population, marking the work as different from the traditional body of transition literature.

DEDICATION

I would like to dedicate this thesis to the participants from my study. Without their honesty, commitment and willingness to share their personal journeys with me I would never have been able to complete this study. The client participants, especially, knew the results of this study would not affect their transition plans; however, they were keen to be involved because they wanted to see a better future for those who were coming after them.

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Completing my PhD had been a goal of mine for many years; in fact, I can recall memories from when I was around 16 or 17 years of age telling my school friends I would one day complete this qualification. What I know now, that I certainly did not comprehend then, is what completing a PhD actually means, or how much work truly goes into completing it. Often, during this quest to complete my doctorate, I found myself relating my journey to the proverb “it takes a village to raise a child” because I have come to realise it has taken a village to complete this PhD. There are numerous people I would like to thank, because without their invaluable input and support I would never have got to this point.

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GLOSSARY OF TERMS

Aotearoa	Māori name for New Zealand. Often used in conjunction with New Zealand
Kāumatua	A Māori elder who is held in high esteem
Māori	Indigenous population of Aotearoa/New Zealand
Occupation/s	All activities an individual engages in that are purposeful and/or meaningful or are required to complete
Pakeha	Māori word to incorporate all ethnicities non-Māori
Recidivism	Refers to the reoffending of an individual
Systems	Includes individuals, groups and larger communities
Tangata Whaiora	Māori name for mental health clients. Literal translation is “people seeking wellness”
Whānau	Māori word for family and includes extended family. Often used in conjunction with the word family

ABBREVIATIONS

CP(MIP) Act (2003)	Criminal Procedures (Mentally Impaired Persons) Act (2003)
CTO	Community Treatment Order
DAMHS	Director of Area Mental Health Services
DSM-V	Diagnostic and Statistical Manual of Mental Disorders Manual, fifth edition
GLM	Good Lives Model
MH (CAT) Act (1992)	Mental Health (Compulsory Assessment and Treatment) Act (1992)
NGO	Non-Government Organisation
ProLad	Progression Ladder Approach
RFPS	Regional Forensic Psychiatric Service
ROG	Residential Options Group
SDT	Self-Determination Theory
SPRG	Special Patient Review Group
WINZ	Work and Income New Zealand

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BILLY'S TRANSITION

Billy¹ (not his real name), who identified as both Māori and European, came into the forensic psychiatric service at the age of 29, approximately eleven years ago, after committing a violent attack on a stranger in a busy central city district. He had stabbed the stranger numerous times in an attempt to kill the person. Billy had believed the stranger was the devil in disguise and that God required him to destroy all things evil. Though Billy did have an extensive criminal history, he was found not guilty by reason of insanity and was held as a Special Patient within the forensic psychiatric service. Previously, Billy had been diagnosed with a psychotic illness in his early twenties and became agitated, confused, suspicious and paranoid when unwell. His illness meant he did not know what he was doing at the time of the attack. Though Billy had been prescribed antipsychotic medication to treat his illness he had stopped taking the medication over six months prior to the attack. Billy also had an extensive history of abusing alcohol and using illicit drugs. Billy spent close to eight years in the forensic psychiatric hospital wards before commencing his transition back into the community. Like the other Billys in this thesis, forensic psychiatric clients come under the health system rather than the correctional service.

Billy was admitted into the secure ward within the forensic psychiatric service during his court appearances for the attack. At the ward, Billy was unable to leave when he wanted because of the locked doors to the outside world. He was also unable to access certain areas within the ward, such as the kitchen, activities room or laundry, without permission and having staff accompany him. Monitoring Billy 24 hours a day seven days a week ensured the health and safety of both clients and staff within the ward. Initially, Billy was distressed about being on the hospital ward because he did not believe he was unwell as he was completing God's work. During this time, Billy was encouraged to engage with the assessment process and interventions of the different members of the multidisciplinary clinical team which included those from occupational therapy, social work, nursing and clinical psychology. At times he became aggressive

¹ Billy is a composite character. He is not one person but rather representative of forensic psychiatric clients who undergo transition. He has been used as an organisational tool within this thesis.

with staff, shouting and posturing, and he would refuse to involve himself with staff or the different treatment activities put to him. Billy continued to believe the work he was doing for God needed to be his focus.

Billy was required to restart taking antipsychotic medication to address the range of psychotic symptoms of his illness. It took several years to finally get Billy on the right medication, and doing so reduced the psychotic nature of his illness. Billy struggled with his responses when talking to other people, owing to his poverty of thought/speech, and had limited motivation to participate in the usual activities of living, such as personal hygiene maintenance. His affect was also blunted, meaning he outwardly showed a limited range of emotions to others.

During the first two years of Billy's transition he began to engage regularly with the range of health professionals and the Māori health worker in his clinical team. Billy participated in a variety of one-on-one treatments with the different members of his team, along with the group programmes which were available on the hospital wards. Areas he addressed included reoffending, living skills, such as budgeting, cooking, leisure activities, and illness management, such as identifying triggers and early warning signs of his illness and drug and alcohol cessation.

Billy was encouraged to connect with his family/whānau as a way of re-establishing his relationship with them. Though Billy had expressed enthusiasm about this, his family/whānau were initially reluctant due to being frightened of him. His family/whānau had not had regular contact with him for many years prior to his attack on the stranger and his subsequent admission to the forensic psychiatric service. The clinical team met with Billy's family/whānau to gather information to help them with assessments, to provide the family/whānau with information on Billy's progress, and to support the family/whānau to reconnect with Billy. Billy had given consent for his information to be passed onto his family/whānau. In time, Billy's family/whānau began monthly supervised visits with Billy in the visitor's room of the secure ward, and because of the success of these visits his family/whānau increased the visits to weekly. Initially these visits were supervised by one clinical staff member from within the secure ward to ensure the safety of both Billy and his family/whānau. At the request of Billy's family/whānau, the visits became unsupervised as they felt comfortable being alone with him.

Because of his legal status, Billy was not allowed to leave the secure ward so all his treatment occurred within the ward environment. However, as Billy began taking part in his treatment and spending time with his family/whānau, the clinical team assessed Billy's risk of absconding was minimal, and the benefits of being out of the confines of the hospital ward was also important for Billy's recovery.

Owing to this progress the clinical team made a recommendation to the Special Patient Review Group (SPRG) that Billy be allowed to start escorted leave with staff on the hospital grounds. The SPRG review incorporated a comprehensive multi-disciplinary panel, including Billy's case manager, responsible clinician, cultural advisor, occupational therapist, social worker and one external psychiatrist with knowledge of forensic psychiatric services. The review group supported this recommendation and a successful application to the Director of Area Mental Health Services (DAMHS), based in the same city as the service, occurred. Billy then commenced daily 30 minute escorted walks in the hospital grounds. The hospital grounds were outside the forensic psychiatric hospital boundaries but had clear boundaries which demarcated it from the wider community. The hospital ground's boundaries were a mixture of fences and open areas marked by the grassed areas (Figure 1 – C on the map). Billy, and the other forensic psychiatric clients, were aware of the exact location of the hospital boundaries even though not always a solid partition marked the boundary. Billy always ensured he kept within the hospital boundaries during his leave. Billy greatly appreciated these opportunities to get out of the confines of the secure ward. Though the secure ward had a large courtyard where he could spend time in the fresh air each day, walking, playing sport or sitting on the grass, the opportunity to be out of the confines of the ward was beneficial for Billy.

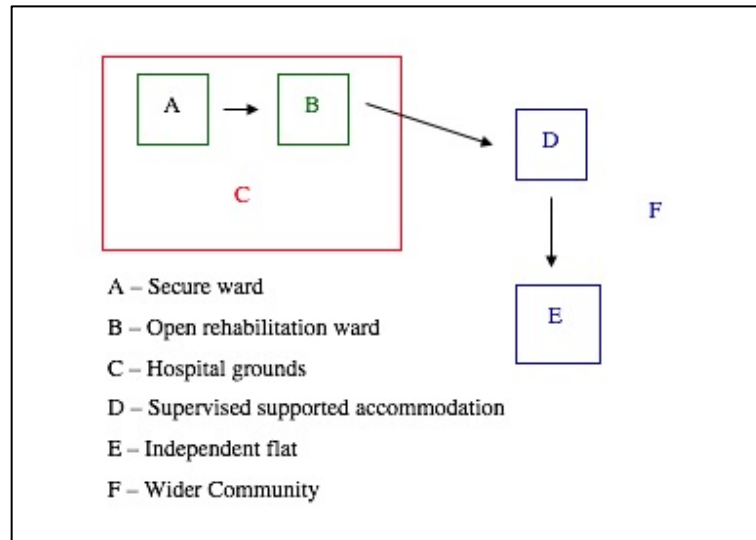


Figure 1: Map

Billy's transition was gradual and after six months of successful escorted leaves the clinical team went back to the SPRG recommending Billy be allowed to commence daily 30-minute unescorted leave on the hospital grounds. This would then allow Billy an opportunity to be away from the supervision of his clinical team and to have time where he could choose to either walk around the grounds or enjoy a coffee at the café which was within the hospital grounds. The SPRG supported the recommendation and the DAMHS granted the application. Billy commenced taking his daily unescorted leaves and ensured he took them every day for the full 30 minutes. He knew how the transition worked. He knew if he did not take his full allocated 30-minute walks every day then it was likely he would not have the clinical team's support for increased leaves in the future.

Alongside the successful application for unescorted leaves within the hospital grounds the clinical team also recommended to the SPRG Billy be given leaves to the local town for up to four hours a week, escorted by staff. Escorted town leave enabled Billy to participate in the ward's weekly supervised town outing with other clients and enabled him to complete activities he wanted, such as going to the movies, clothes shopping and visiting his family/whānau at either their home or at a local café. Approval for this increase in leave was required to go to a different person to the one who approved his ground leave. The Director of Mental Health, based at the Ministry of Health in Wellington, was required to approve any leave, for Billy, which was off the hospital grounds. After several months, approval was granted for this expansion in Billy's leave. This transition did not go smoothly.

Because Billy successfully maintained his unescorted leave in the hospital grounds and his staff escorted leaves into town for many months, his clinical team was seriously considering applying for unescorted leaves to town and had started discussions with Billy about his plans. These discussions included what support and rehabilitation needs he had for his future. Billy found the pressure of considering his future outside of the secure environment overwhelming and he became anxious. As a result, Billy consumed “legal highs²” during one of his unescorted leaves on the hospital grounds and his mental state decompensated. He became unwell, behaving erratically, and became suspicious and paranoid of those around him. His focus on having to complete God’s work returned as did his need to eradicate evil from the world. As a result, Billy’s leave on the hospital grounds and escorted town leave were suspended and he remained 24 hours a day, seven days a week, within the secure ward (Figure 1 – A on the map).

Over the next three years Billy eventually regained his leaves, and his advancement from escorted ground leave to unescorted ground leave to escorted town leave progressed at a slower rate than his initial progression. This slower transition enabled Billy to feel more secure in his recovery. Billy maintained his wellness during this time and the clinical team assessed Billy as no longer needing the security of the locked ward. Again discussion restarted with Billy about where he would go after the secure ward. Because he had been in the secure ward for just over five years, the clinical team recommended Billy be transferred to the open rehabilitation ward (Figure 1 – B on the map) within the forensic psychiatric service to allow Billy to develop skills and capabilities he would need for community living and for maintenance of his specialist forensic psychiatric service oversight.

The open rehabilitation ward was what Billy dreaded. He had wanted to go directly to the community; however, he was aware this would be unlikely owing to his Special Patient status and if he did not agree to the graded transition he would remain in the secure ward. Billy was required to learn a different set of rules and procedures at the open rehabilitation ward. Billy could now access the kitchen and dining room when he

² Legal highs are psychoactive drugs which have been manufactured and marketed with the aim of avoiding legislative restrictions. They contain various chemical ingredients, of which some are illegal, and others are not. They have similar effects on a person as illegal drugs such as ecstasy and cannabis (Winstock & Ramsey, 2010).

wanted so he was now responsible for planning and cooking his own breakfast and lunch. He was also expected to work with other clients to prepare and cook evening meals all the clients would eat. Billy was expected to stay on the ward when he was asked to by staff, even though the front door was not locked. Billy could now access areas of the ward without the need for staff to unlock doors such as the laundry and activity room; however, he was also expected to limit his access to these areas when instructed by staff.

I first met “Billy” when he was transferred to the open rehabilitation ward and there he told me this story. It was a common story. He was excited about being out of the secure ward but very apprehensive about being in a new environment in which he had to learn the rules and get to know both staff and other clients. Billy spent six weeks transitioning from the secure ward to the open rehabilitation ward. He initially spent two afternoons in the first week at the open rehabilitation ward, and because that was successful he then spent two full consecutive days the following week at the open rehabilitation ward, though returning to the secure ward to eat his dinner and sleep. Gradually over the next four weeks Billy increased the time he spent at the open rehabilitation ward, including staying for dinner and then spending a night at the open rehabilitation ward. In Billy’s final week before moving permanently to the open rehabilitation ward he spent four full days there, including nights. The transition was regarded as a success and Billy moved permanently to the open rehabilitation ward so his treatment was now overseen by the clinical team there.

When Billy moved permanently to the open rehabilitation ward all his leave was temporarily suspended to allow the new clinical team to assess Billy. He was required to stay on the ward, though the door to the outside of the open rehabilitation ward was not locked. He was expected to restrain himself and to not leave the ward. I could see this restriction was incredibly frustrating for Billy, especially since he had been attending escorted town outings from the secure ward. Billy coped ok and his unescorted leave in the hospital grounds and escorted town leaves were subsequently reinstated after he had been on the open rehabilitation ward a week.

Billy took part in the range of programmes on the open rehabilitation ward as he wanted to demonstrate to staff he was trustworthy and willing to participate with treatment. He continued to focus his treatment on the areas of reoffending, illness management, drug and alcohol cessation and living skills. Billy’s Special Patient status

remained so any further community leave applications were required to be supported by the SPRG before being submitted to the Director of Mental Health.

At this stage, Billy had been in the hospital for almost six years. Billy spent a further two years living permanently at the open rehabilitation ward. During this time, his leaves increased. He was initially granted escorted town leave to a destination but unescorted at his destination, this allowing him to attend classes at the local high school and to complete work experience for three hours a week. Billy was successful in these tasks which led to him increasing his leaves to unescorted community leave up to eight hours a day. Billy also started taking part in the cooking in the open rehabilitation ward. He, alongside another client, would cook dinner for their fellow clients once a week. He helped with meal preparation and making decisions on what groceries should be bought each week. He accompanied the open rehabilitation ward's welfare officer to the supermarket and helped with a range of ward maintenance tasks such as doing laundry. As part of his treatment, Billy also spent time in town, escorted by staff, building his confidence using the bus system, accessing the library and interacting with members of the public. Billy's family/whānau continued to engage with him and spent time alone with him on the grounds, either walking or going to the café.

At the end of these two years the clinical team believed Billy was ready for this next step. Billy's family/whānau had advised they were not comfortable with having him live at their home at this stage though they wanted to continue supporting him and being actively involved with his treatment. Billy was told he would be transitioned into the community through a 24 hours, seven days a week, supported accommodation provider (Figure 1 – D on the Map). This type of accommodation was situated off the hospital grounds and in the suburbs of the local town. The housing was close to a local shopping mall, bus stops and a park. The building was a large modern complex and comprised several single units and two-bedroom apartments. On the outside, it looked no different from the other houses on the street; however, the complex had an office area where the support and clinical staff were situated and the staff were available seven days a week, 24 hours a day. Initially, Billy was frustrated with this slowness of his transition as he wanted to go directly back into the community, living with his family/whānau; however, he knew if he refused to go to the 24 hours, seven days a week, supported accommodation he would remain in the open rehabilitation hospital ward. Plus, Billy knew he had not spent time completing the usual tasks and activities

associated with living in his own home since being in hospital. The thought of completing these activities had been anxiety provoking for Billy and he was really grateful that he would have the support of staff within the supported accommodation who could help him with these everyday tasks. He had been especially concerned about using the buses, attending Work and Income New Zealand (WINZ) appointments and completing his grocery shopping.

Billy was allocated a single unit within the supported accommodation complex which the staff wanted Billy to see as his flat and to make it comfortable as his home. He was advised by both the staff at the supported accommodation and the hospital that this accommodation was not permanent. He would be there for several months or years and would eventually move into a flat where there was not 24-hour supervision (Figure 1 – E on the map). Eight years after being in hospital Billy started his transition to the supported accommodation by spending half days, three times a week at “his” flat. As there were no organised programmes for him to engage in he spent his time making his flat a home for himself. He later moved on to spending whole days at the flat, but returning to the open rehabilitation hospital ward for the evening and night. Billy was expected to make his own way to and from the step-down accommodation and the open rehabilitation ward. He often walked or used his bicycle. Because of the success of the increasing time at the supported accommodation for Billy, his clinical team successfully applied to the Director of Mental Health for leave from hospital up to six nights a week. This meant Billy could live permanently at the supported accommodation but had to go back to hospital one night a week. At this point, Billy’s clinical oversight was transferred from the open rehabilitation ward team to the community forensic psychiatric team though he was still required to spend a night a week in hospital. Living at the supported accommodation meant Billy was required to adjust again to different rules. Mainly, there was a reduction in expectations of what Billy was required to follow. He was required to inform the staff of the supported accommodation of when he was leaving the grounds and when he had returned to his flat. This was a health and safety requirement to allow staff to know which clients were within their flats. If Billy had any visitors they were required to sign the visitors book, located in the office, when they arrived and to sign out when they were leaving. Billy was required to keep his flat clean and tidy and to cook all his own meals. He was also required to shop for his own groceries and manage his budget.

Billy lived at the supported accommodation for a further two years during which time his confidence in his own ability increased. Billy would also spend whole days with his family/whānau; however, he was not allowed to spend any overnights with them as he did not have the necessary approval. He worked closely with his community support workers and his case manager from the community forensic psychiatric team to ensure he remained focused on his recovery. Billy completed several training opportunities including foundation studies in literacy and numeracy. Periodically, Billy obtained employment, such as breaking down old unusable computers, loading and unloading shipping containers and sweeping up at building sites, though none of it was permanent. The jobs tended to be secondary labour jobs and Billy got frustrated with his lack of continued employment and lack of funds. Billy was dependent upon the benefit he received to live.

After two years living at the step-down accommodation, ten years into his transition, Billy's clinical team successfully applied to the Minister of Health for Ministerial Long Leave. An initial period of six months was granted. This allowed Billy to spend seven nights a week in the local community without the need to return to the hospital each week. At this point, Billy moved into an independent flat with support staff visiting him weekly to ensure he was maintaining his wellness. He had developed a small network of friends with whom he kept regular contact. He enjoyed meeting at his friends' places for coffee. Billy had not found permanent paid employment but would have very much liked to. He had completed a range of training courses as an attempt to make himself more attractive to potential employers. He had not had success yet.

Billy now saw himself as someone who would not return to the criminal behaviour of his past. He had worked hard to address his drug and alcohol dependency and he knew that having support of his family/whānau, friends and the health professionals was what was keeping him well in the community. He saw himself as a very different person from the one who was first admitted to hospital almost ten years ago. Billy dreamed of one day no longer being a Special Patient and no longer being a forensic psychiatric client.

As Billy's success endured I found myself pondering whether Billy's story was unique or did each client have an idiosyncratic pathway from forensic psychiatric hospital to the community. Within my role at the forensic psychiatric service I saw many Billys

and some were similar; however, others were different. Yet, each had their own transition.

WHAT DREW ME TO THIS STUDY

My interest in transitions, and specifically transitions completed by those within forensic psychiatric services, initially arose from my time working as an occupational therapist within forensic psychiatric services where I met the clients, similar to Billy, during my job. One of my main roles was to assess what needs a person had when moving back to the community, including how well they were set up to look after themselves independently, how they engaged with others, what their prospects were of holding down employment, and their strategies, if any, to keep themselves well. I would make recommendations to the wider team and decisions about where an individual would then move to next, would occur. Often decisions included making referrals for further rehabilitation within the hospital setting, intensive supervision in the community or independent accommodation. I was asked so many times, “What’s it going to be like?”, “How am I going to cope with no locks again?” and “What am I going to do when I’m out?”. I also had the privilege of accompanying clients on their first trip into the community after, sometimes, decades of secure containment. Seeing the anxiety and sometimes fear at the thought of having to speak to a person at a supermarket, or the confusion about using new technology, such as a smart phone, or anxiety about getting on a public bus, led me to wonder, “How do these clients make this adaptation?” I was left wondering how I could alleviate their anxiety as this was not a transition I had completed before and I was unable to use my own experience to support the clients.

My interest developed further after completing my Master’s degree which explored the transition experience of moving from a secure unit to an open rehabilitation ward within a regional forensic psychiatric ward (Kinney, 2011). I searched the literature to see what I could find in regard to transitioning within the forensic psychiatric service and interestingly, though after consideration, unsurprisingly, I discovered very little literature exploring the transition and adaptation process that an individual goes through from the perspective of the individual themselves. I did find literature which focused on recidivism, risk management, medication compliance and descriptions of programmes used to move clients out of hospital. There appeared to be a gap in the

literature on how individuals process their transition, as well as a gap on the voice of the person within forensic psychiatric services undergoing this transition.

The story of Billy has been told from my perspective, it is my understanding of what Billy has gone through as he has progressed from hospital to the community within the forensic psychiatric service. I am mindful I have not undergone this type of transition before so do not have this unique perspective, I can only tell this story as an outsider. Therefore, exploring this adaptation process through the lens of an insider would be an important contribution to the current body of knowledge.

The aim of this research is to explore the transition process for clients, like Billy, of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand by asking three main questions:

- How do those moving to living in the community, within a forensic psychiatric service, adapt to this situational change?
- What influences the transition experiences of those moving to the community within a forensic psychiatric service?
- What would transition success look like?

The chapters that follow seek to understand how clients, like Billy, adapt to living in the community again after a significant period within the forensic psychiatric service hospital system.

The thesis is organised around ten chapters:

Chapter two begins by theorising Billy's transition. The transition that Billy underwent was unique and is not captured in the transition literature. George (1993) contends the heterogeneous nature of transitions and reliance on social context makes a single generic framework to explain what is happening impossible. Transition is placed within a sociological context and explores the connection between socialisation and transition experiences. The concept of social transitions is presented and two types of social transition, life course and social role transition, are explored because of their relevance to this study. Adaptation is a central process an individual goes through during times of change. Internal and external factors which influence transition, including agency, coping strategies, meaning-making, self-determination, self-efficacy, self-identity and support are identified and linked to forensic psychiatric community transitions. Community transitions are also impeded by barriers including stigma and

discrimination, labelling and Otherness. Finally, outcomes of transitions to the community are reviewed, including recovery, social exclusion and transition shock.

Chapter three presents the literature on transition frameworks relevant to the study. Part one begins with overviewing six generic frameworks. Aspects of each framework provide insights into the transition process undergone by individuals. The Being, Becoming, Belonging framework is included in the review because of its usefulness when considering forensic psychiatric transitions. Part two reviews transition literature from specific fields which have a crossover nature with forensic psychiatric services. It begins with transitions from hospital to the community within general mental health services. Challenges that can be experienced during the transition are outlined and the transitional relationship framework is reviewed. Focus turns to the correctional service literature and begins with reviewing resettlement literature. Successful transitions from corrections to the community are linked to desistance from offending and employment being secured. The forensic psychiatric service literature acknowledges the multiple challenges experienced by clients who are re-integrating back into the community. Transition plans are used to provide structure and guidance for both staff and clients and the plans' focuses should remain on the clients' needs. Three frameworks are then reviewed. Though useful, none of the three frameworks provide insights into how clients adapt to living in the community. The chapter finishes by identifying the gaps within the literature, a lack of explanation of how a client adapts to living in the community again and a lack of clients' voices within the current literature. The need for the study is then justified.

Chapter four provides insight into the unique social context in which the transitions occur and is a historical review of forensic psychiatric services both internationally and in New Zealand. Part one begins with an overview of the McNaughton case which distinguishes between the health system and the corrections system. The outcome of this case affected how the forensic psychiatric population was defined, how services were structured, how clients like McNaughton were treated and how this has produced challenges for both staff and clients. The power imbalance which influences transitions within the forensic psychiatric service is explored. Connections to the works of Foucault are made. Part two focuses on New Zealand and how forensic psychiatric services have evolved following two major incidents and the defining Mason Report. Although New Zealand is influenced by the McNaughton rule, there are unique cultural

and legislative distinctions. The chapter ends looking at a report 'Rising to the challenge: The mental health and addiction service development plan 2012-2017' that opens the door for people like Billy and is at the very heart of this thesis.

Chapter five, the methodology, overviews the paradigms and theories that have guided this study. The paradigms of constructivism and pragmatism are explored, then I consider the use of symbolic interactionism and the use of constructivist grounded theory for my study. Next, the rationale for the inclusion of various data collection methods in this study is provided. The methods used were semi-structured, intensive interviews, and walking interviews. I then address the need for rigour in this research and how these were achieved by using the criteria of credibility, transferability, dependability and confirmability. The chapter ends with a focus on reflexivity.

Chapter six gives an account of the research process. It begins by exploring the ethics approval process and the identification, recruitment and selection of participants. Next, data collection is covered, as well as an overview of the characteristics of the clients and staff. Following on from that I cover how the interviews were undertaken and some of the challenges of conducting research with the participants. The chapter finishes by exploring the use of grounded theory for the analysis of the interviews.

Chapter seven presents The Apparatus of Transition, the first of the two results chapters. The apparatus refers to the various mechanisms and structures that control individuals during their transition process. This chapter explores the factors which make up the apparatus and the ways the staff and clients attempt to counteract that apparatus, in order to enable clients to live the life they wish for in the community, as well as the key features for ensuring the success of the transition. Four major categories arose, *Negotiating the Apparatus*, *Providing Opportunities*, *Creating a Safe Haven*, and *Factors for Success*.

Chapter eight presents the personal journey of transition and it is titled Regaining Autonomy in a Non-Autonomous Environment, the second of the results chapters. Multiple components made up and contributed to an individual's development of autonomy in which they were required to take an active role. Regaining autonomy has four main categories, *Building Self-Determination*, *Inner Thinking: A Reason for Being*, *Outer Thinking: Looking Towards the Future* and *Getting Through It*.

Chapter nine presents my analysis of the data. The theoretical framework, *Being Well, Becoming an Ex, Belonging in the Community* is proposed and provides insights into the process individuals undergo during their transition. The three dimensions of the framework are interrelated and linked by what an individual is engaged in doing. The framework is presented initially as a whole, and then each of the three dimensions is explored in detail. Being Well, a holistic term, is determined by individuals, and incorporates recovery, resilience, and wellbeing. Becoming an Ex involves an individual changing from what was a former identity and incorporates role exit and role transition. Belonging in the Community, for individuals, is developed over the course of each person's transition. Belonging in the Community is demonstrated when each person is engaged in doing purposeful and useful activities with the range of groups they considered important for their life in the wider community.

Chapter ten is the conclusion where all the strands of the thesis are pulled together to ensure a complete picture is presented. Recommendations and implications for practice are presented using the Being Well, Becoming an Ex, Belonging in the Community theoretical framework. Limitations to the study are identified and possible future research directions are offered. The thesis is finished with my final reflections on both my own transition through this process and that of forensic psychiatric transitions to the community.

2

THEORISING TRANSITION

What is learnt from Billy's transition is an indication of what happens in the remainder of the thesis. Forensic psychiatric transitions out of the hospital environment to the community are multilayered and often the literature related to transition focuses on transition as a one-dimensional process. Adapting to living in the community required Billy to undergo multiple transitions within the broader transition of moving from the hospital environment to the community. The transition that Billy underwent was unique and is not captured in the transition literature that is outlined over the next two chapters.

A sociologist, George (1993), also argued transitions are too heterogeneous and reliant on social context for a single generic framework to explain what is happening as individuals adapt to the change they are undergoing. Ruble and Seidman (1996) contend what is known about transitions for individuals is the often positive and negative consequences of the process, while what is not well known is how context influences both the process itself and the outcome of transition. Therefore, it is important the unique features of transitioning to the community clients within forensic psychiatric services undergo from hospital are overviewed. This chapter has been divided into several key headings. Initially, transition is broadly introduced as a socialisation process and then focuses on social transitions, reviewing two transitions forensic psychiatric clients undergo, life course transition and social role transition. Then, an essential component of transition, adaptation, is explored. A range of internal features are then reviewed, such as agency, coping strategies, meaning-making, self-determination, self-efficacy, and self-identity are used by individuals during times of transition. An external feature, support, was also regarded as important for successful transition is also reviewed. Stigma, labelling and Otherness have been identified as barriers to transitioning to the community for clients within forensic psychiatric services and these are presented. Lastly, outcomes to transitioning into the community, which can be varied; are presented. These can include recovery, which incorporate concepts of resilience, developing a sense of belonging and well-being, and adverse community transitions, including social exclusion and transition shock.

To begin with, challenges have been exposed in literature about how to define transition, other than to define it loosely as change. At what point the level of change experienced by an individual equates to a transition process was not clear. Some authors define transition in subjective terms, that is, if the event results in both internal and external changes which have long-lasting effects (Anderson, Goodman, & Schlossberg, 2011; Connell & Furman, 1984), while others, such as George (1993), attempt to define the term objectively, for example, resulting in a change of status; however, there may or may not be any subjective effect as a result (Ruble & Seidman, 1996). Both definitions of transition were useful when considering the transition process forensic psychiatric clients undergo when moving from the confines of the hospital ward to the community. During this transition, an individual undergoes a change of status from patient to community participant; however, this change of status will more than likely result in internal and external changes which have long-lasting effects for that person.

Harris (1987) believes transitions are of interest to sociologists and should be central within sociological research because transitions challenge social structure as a fixed entity. For example, George (1993) argues sociologists are increasingly devoted to the dynamics of change and so research on life transitions should be a growth industry within the profession. Social scientists are interested in transitions because of the influence transitions can have on social structure and how the process of socialisation influences an individual's transition experience.

SOCIALISATION OF TRANSITIONS

Giddens (2006) describes socialisation as a process that occurs over the life course where an individual, from infancy, becomes self-aware, knowledgeable and skilled in the ways of the culture he or she is born into. It is expected the young will learn from their elders and then continue to emulate the values, norms and social practices they have learnt. Socialisation, like transitions, occurs throughout life and at distinct phases. Some transitions will be anticipated and planned for; however, many will be unanticipated and a result of crises, unplanned or unexpected events. People will then need to adapt their ways of being, to incorporate these changes into their lives. George (1993) contends the process of socialisation provides individuals with the knowledge and skills to master life's transitions and to master changing roles that occur as a result.

Roles individuals enact are generally aligned with the attitudes and skills an individual has developed through the process of socialisation over the course of their life.

Goffman's (1961a) work, 'Asylums: Essays on the social situation of mental patients and other inmates', has particular relevance to the forensic psychiatric population. Goffman asserted it is the institution that forms the patient in the institution, not their illness, and the behaviours observed by patients can be seen in people in other institutions as well. Goffman painted a picture of asylums as being systems that force patients to endure humiliations, to accept restrictions, to adapt their behaviour and thinking, to fit within institutional life and to define themselves as mentally ill. Though the research was undertaken over 50 years ago several points Goffman makes are pertinent to this study. Forensic psychiatric clients have been in hospitals for many years, and they have become socialised to the way the hospital works and will do what they need to, to ensure they survive. There are multiple restrictions for clients within forensic psychiatric services; the hospitals have highly structured rules and regulations all clients are expected to follow. Challenges include defining themselves as a non-patient, being able to work out the appropriate behaviours for community living and to adjust to a life that is very different from where they have been living for the past multiple years. Petch (2009) claims transitioning to the community requires each client to re-socialise to an environment which may be both familiar and unfamiliar to them and, therefore, moving from hospital to the community can be fraught with uncertainty.

A research project exploring how individuals transition to living in the community, that is, how they re-socialise to this familiar, yet foreign, environment again is appropriate within sociology. This transition process of re-socialising to the community is likely to be unique for each person. Ruble and Seidman (1996) contend the study of social transitions is of interest to social scientists because of the impact transitions can have on an individual's social functioning, self-definition, and relationships.

SOCIAL TRANSITIONS

Social transitions incorporate all types of transitions which impact on social processes and cover the movement an individual goes through during their life. Social transitions include the transition in cultural expectations, changes in social status, developmental changes about being in their world and changes to the social roles an individual engages in (Kralik, Visentin, & Van Loon, 2006; Ruble & Seidman, 1996). Moving

from hospital to the community within a forensic psychiatric service impacts on social status, how an individual views him- or herself as being part of their world, and the social roles they take. Therefore, for this thesis the transition being explored is regarded as a social transition and from this point forward social transition will be referred to as transition only. Being aware of and understanding the transition process means help can be offered to those undergoing this adaptation when needed (Kralik et al., 2006).

Change is a core concept of transition (Bridges, 1996; Brown, Kraftl, Pickerill, & Upton, 2012; Connell & Furman, 1984; Duchscher, 2009; Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Transitions are a result of, and result in, a change in an individual's life, health and relationships. Tackling the differences between the way things were before the change occurred and the way things are now, perceived or actual, is fundamental to the transition process (Meleis et al., 2000). Transitions require people to adapt to their changing situation. Transition is not regarded as an event but rather as a psychological reorientation people go through to incorporate change into their lives (Bridges, 1986; Meleis et al., 2000; Rittman, Boylstein, Hinojosa, Hinojosa, & Haun, 2007). Billy underwent many change events during his involvement with the forensic psychiatric service, and each had a great impact on him. Each of the events required Billy to adapt to his changing situation to enable him to progress as he hoped for his future. For example, moving to the open rehabilitation ward, which was a less-restrictive ward, from the secure hospital ward, meant Billy was required to do things differently. He was no longer required to ask permission to access the kitchen or laundry, which meant he could choose when he wanted to eat or when he wanted to wash his clothes. Not automatically approaching staff to ask for permission took time for Billy to incorporate into his life. Moving out of the open rehabilitation ward to the supported accommodation within the wider community was another example of an event that impacted on Billy and required him to do things differently. Billy could now choose what time he got up each morning, he could plan what activities he would fill his day with, and change his mind if he wanted. He was not required to seek permission when he wanted to leave his flat to go grocery shopping. It was the transition processes Billy underwent in response to these events which enabled him to adapt and incorporate the change into his life.

At the heart of transition is the understanding that when an individual's current reality is disrupted they are either forced or choose to change. Individuals must then create a new reality for themselves (Bridges, 1996; Kralik et al., 2006; Rittman et al., 2007). Selder (1989) suggests the purpose of reconstructing a new reality is to create new meaning where old meanings have been fractured. This process occurred at multiple points for Billy. For example, a time when Billy was required to create a new reality for himself was when gained unescorted leave within the hospital grounds. Billy's reality for approximately the two years previously was one where he was constantly being observed. While on the hospital ward cameras kept staff aware of what Billy and the other clients were doing. He was only able to have privacy when he went to the bathroom or was spending time in his bedroom. Though Billy could leave the ward during this time for a period of 30 minutes he still had staff accompany him, talking to him and observing him. When Billy obtained unescorted leave within the hospital grounds he could take advantage of an opportunity to have time by himself, without a staff member observing him. This new reality took time to get used to for Billy.

Meleis and colleagues (2000) believe how transitions are processed is uniquely individual and will sometimes result in changed behaviours. Merriam (2005) asserts transition involves letting go of the past, experimenting with strategies to accommodate the new and finally feeling comfortable with the changes. Hudson (1999) stated a transition is a time to hold on to what is working, to let go of what is not, to take on new learning, and to explore options. Nortier (1995) believes transition is often an internal process for an individual. It happens progressively and is not demarcated by time. The success of a transition is directly influenced by the success of past transitions. These characteristics of transition can be seen in the transitions of forensic psychiatric clients like Billy. A significant transition for Billy was moving from the hospital ward to his supported accommodation. How he saw himself, the roles and responsibilities he now held, and how he completed his everyday activities changed. Billy gradually moved to living at the supported accommodation and this was needed to allow Billy to work out what he wanted, and sometimes needed, to change to ensure the success of his community move. It took time for Billy not to automatically look for staff to approve when he could eat his meals, when he would rise each morning and if his friends could visit and to work out what worked for him.

Meleis and colleagues (2000) believe that to truly transition, individuals' need to be aware a change is taking place for them, that they must have an awareness their reality is changing and that they are required to make alterations to accommodate these changes. Awareness and recognition an individual will be required to do things differently in the future is important for the success of the adaptation. A lack of awareness, that is, a lack of recognition reality is changing for an individual and how it will impact on them, may indicate the individual may not be ready to process the transition. A lack of awareness will not prevent a change event from occurring but it will influence the degree of engagement an individual will take into adapting to the change event (Clingerman, 2007; Kralik et al., 2006; Meleis et al., 2000). Anderson and colleagues (2011) contend part of demonstrating awareness is acknowledging and evaluating the impact the transition will have for individual, and this level of awareness will influence how an individual feels and copes with the transition and the meaning it holds for them. Importantly for Billy, recognising the increase in liberty he was gaining would impact on his current reality. Billy would now complete many of his usual daily activities differently; for example, no longer needing to ask for permission to leave his flat or cooking meals at a time that suited his routine meant he was gaining freedom and that freedom could be both liberating and overwhelming.

Engagement is important: that is, the degree an individual becomes actively involved in the adaptation process, after demonstrating awareness of the transition process has occurred (Kralik et al., 2006; Meleis et al., 2000). It is often only after an individual realises their reality is now different and that the way they have done things in the past no longer works do they deliberately engage with the transition process. When an individual is undertaking activities that allow him or her to fully participate in the transition process then they are regarded as engaged. Individuals will be actively making decisions about their transition as they are immersed and engaged in the process. The level of awareness an individual has about the impact of their transition will influence the degree an individual will engage in decision-making about their transition. (Clingerman, 2007; Kralik et al., 2006; Meleis et al., 2000). Billy's engagement with his transitions included choosing to engage with his clinical team in activities such as counselling, participating in the range of group treatment options, learning how to use the buses, and budgeting. These enable clients like Billy to build their confidence and capabilities to ensure they successfully complete their transitions.

Transition has the potential to have many impacts on an individual, some of which can be overwhelming for a person. Nortier (1995) argued when an individual is labelled “resistant to change” what actually is meant is that there is resistance and apprehension about having to cope with the change. Transition will influence an individual’s psychological state, the way they perceive themselves and their relationships with others. Kralik and colleagues (2006) believe healthy, successful transitions are linked to the development of connections to others because connections to others provide support for individuals like Billy to gain awareness of and subsequent engagement in their transition processes.

Transitions are categorised into a range of types, each influencing how a person progresses through the transition. *Anticipated* or *predictable* transitions are those that the individual is expecting and are often associated with being desirable, though not always. These transitions can be prepared for and they progress in an expected manner (Adams, Hayes, & Hopson, 1976; Merriam, 2005). These include events that the individual knows are coming and usually include the “normal” events that occur during a life course such as having children, leaving home, moving from student to worker, or moving into retirement (Anderson et al., 2011). Within forensic psychiatric services these transitions include gaining increased leave and moving out of the hospital ward to the community.

Unanticipated or *unpredictable* transitions are those that were not expected by the individual and are often associated with being undesirable, and often the transition does not progress in a manner that is expected (Adams et al., 1976; Anderson et al., 2011; Merriam, 2005). These transitions are non-scheduled over a life course. They can be associated with crises and unpleasant feelings; such transitions would include, the death of a loved one, being demoted, job loss, a natural disaster and illness. Anderson and colleagues (2011) assert unanticipated transitions can pose unique challenges for an individual because he or she has not had time to prepare themselves. Within forensic psychiatric services these transitions include returning to prison when the client had anticipated staying in hospital or family refusing to be part of a client’s life.

Adams and colleagues (1976) term *voluntary* transitions as being those that an individual chooses to complete. Within these transitions there may be an element of predictability, such as choosing to change employment or getting married or unpredictability, such as going on a blind date. They also explain *involuntary*

transitions as being those that an individual does not choose to participate in; however, they will still undergo them. Within these transitions there may be an element of predictability, for example, going to prison or unpredictability, or a natural disaster such as an earthquake (Adams et al., 1976).

Non-events are the transitions an individual will undergo when an anticipated event does not occur (Goodman, Schlossberg, & Anderson, 2006; Merriam, 2005; Schlossberg, Waters, & Goodman, 1995). This type of transition can be significant for those within forensic psychiatric services. Increased leave, obtaining parole or being discharged from hospital directly into an independent flat are examples of anticipated events for clients within these services that may become non-events when they fail to occur.

Merriam (2005) define *sleeper* transitions as those events that occur gradually over time, often initially unnoticed but that accumulate in change of the individual's roles, relationships and routines. For example, the building of confidence, competence and independence, within employment or living in the community occurs over time for clients within forensic psychiatric services. The amount of time needed for each person is unique to them.

The number and types of social transitions individuals within forensic psychiatric services undergo over their time within the service will be unique and too numerous to detail in this review. Unanticipated events such as the loss of loved ones, returning to prison or the development of a serious physical illness can occur for some clients but not for all. Two specific types of transitions, life-course transition and social-role transition, have been included in this review because it is likely individuals, within forensic psychiatric services, will experience these during the process of moving from hospital to the community.

Life Course Transition

Life course transitions are the transitions that an individual undergoes over the course of their lives, when they move from one life phase, condition or status to another. These are not necessarily seen to occur just because a person passes through another birthday as they move from being a child to becoming an adult (Brown et al., 2012; Kralik et al., 2006; Valentine, 2003). Life course transitions generally fit within the anticipated (Anderson et al., 2011) and predictable (Adams et al., 1976) categories

because these transitions are expected and can be planned for. Transitions from childhood to adulthood were often assumed to be linear. Moving into employment, moving out to the family home to being financially independent is the naturally expected linear progression for individuals. However, life course transitions are now seen as being complex and often fluid, with often those individuals yo-yoing between some of the progressions. For example, a child leaves their family home to live independently because they have secured employment; however, after losing their job the child moves home because they need financial support from their parents. This unplanned return to dependence can cause friction for both the child and the parents because of the unanticipated nature of the transition (Valentine, 2003; Wyn, Lantz, & Harris, 2012).

Warr (1998) asserts life course transitions, such as forming important intimate relationships, specifically marriage, and gaining employment have been found to support desistance from crime, which can be important for some clients within forensic psychiatric services. Marriage has been found to disrupt established relationships with other offenders that existed prior to the marriage. Having an important intimate relationship encourages the reduction of time spent with friends who would be deemed as deviant and thus helping to dissolve those relationships and build conformity and attachment to conventional norms. Visser, Winterfield, and Coggeshall (2005) also explain moving into employment that is stable and satisfying has also shown to support the desistance from criminal behaviours because it provides financial stability for an individual and encourages the individual to behave in socially expected norms. Many forensic psychiatric clients, for a variety of reasons, such as chronic mental illness and criminal histories, have not experienced secure stable employment or established an ongoing intimate relationship.

Life-course transitions have relevance for forensic psychiatric services, and this research project, as forensic psychiatric services provide input for a wide range of individuals over the life span. The impact of aging, whether an individual has lived independently previously, whether an individual has a history of stable employment, or whether an individual has had a significant intimate relationship, all have the potential to influence how an individual successfully adapts to living in the community. To complete any of these transitions requires an individual to assess the social roles they are currently engaged in and whether those roles require altering.

Social Role Transition

Turner (1968) defines social roles as the collection of behaviours and associated attitudes that are seen to belong together which provide strategies for coping with persistent social situations. An individual performs a social role in a way that is recognisable to others and it provides a basis for distinguishing and placing an individual in a group, organisation or society (Turner, 1968). The vast majority of social roles exist in pairs; for example, there is no doctor without a patient or a teacher without a student. Social roles not part of a pair can interact with those of the same role, for example a friend will interact with a friend (Turner, 2001). Turner (1990, 2001) has identified four broad categories of social roles, basic, structural status, functional group and values roles. Considering Turner's (1990, 2001) broad categories in regards to forensic psychiatric clients' transition is important because these will influence how the individual will progress through their transition to the community. For the remainder of this thesis, social roles will be referred to only as roles.

Ebaugh (1988) clarifies roles explain more than social order; an individual's self-identity is intrinsically linked to the roles they carry out. Boyanowsky (1984) asserts roles an individual engages in largely determine self and social identity, therefore, role transition is likely to significantly influence an individuals' view of their social self and in the course of a lifetime individuals will complete a vast number of role transitions. Allen and van de Vliert (1984) explain role transition refers to the process an individual goes through when they are moving from one set of roles to another. Role transition is regarded as important because behaviour and social identity are strongly influenced by this process. Turner (2001) argues role transition can challenge the social relationships within a community, group or organisation. It can undermine predictability and evoke fear and anxiety within the members of the community, group or organisation. Gradual change is not uncommon; however, there can be a tendency to believe that current role structures within a social life should carry on. For Billy, moving to the community required him to transition from roles he had held within the hospital for many years. Within hospital as a patient required Billy to behave in specific ways. Once in the community he was required to act differently and this was not always effective.

Duchscher (2009) explains role transition is a non-linear process, which moves an individual through the developmental, professional, intellectual and emotional skill and

role-relationship changes. The experiences, meanings and expectations of the individual are important within this process. Sanders (2007) contends a number of factors, political, cultural and legal factors will influence whether an individual will undergo role transition, while hooks of change, including employment, appropriate treatment for drug and alcohol use and appropriate housing will influence whether role transition can be sustained.

Boyanowsky (1984) contends a role transition process can become complicated and all-encompassing when there is a dramatic shift required for an individual in the roles they are participating in to fit with new identities they are taking on. This is especially relevant when there is a high level of psychological stress, such as moving to the community. The individual in transition can feel forced into roles by the influence of society or other influential people who are performing complementary roles. Sometimes, as a way of coping with the psychological stress, an individual may engage in socially dysfunctional practices, such as abusing alcohol and drugs, as a way of coping with the stress with a hope to reduce the source of the stress. This type of coping was seen with Billy when he experienced a high level of psychological stress during his first attempt to move out of the secure ward. He took legal highs and his mental state decompensated as a result.

Turner (2001) believes choosing to transition into a role which requires new learning can be a challenge when the previous role was comfortable and relatively successful, even when that role is classed as a deviant role. The security of a deviant role which may have familiar friends might be preferred over a socially acceptable role when there is a need to create and nurture new and different friends. For role transition to fully occur the individual must accept the new role and abandon the old; however, they must also be accepted into the new role and no longer viewed as being in the old one by other people.

Role transition is particularly significant for those within forensic psychiatric services. Ebaugh (1988) suggests role transition involves the tension between the past, present and future for individuals, and often roles from the past will linger and influence the lives and conceptions of self in the future. Those in society are aware of ex-statuses and will regard an individual not on whom they have become but rather whom the individual used to be. Roles forensic psychiatric clients hold include patient, offender, drug taker and beneficiary recipient. Returning to the community requires the

individual to work towards negotiating out of these roles; however, challenges will be experienced if those in the wider community are unwilling to support the role change and is doubly so for Special Patients. Part of transition, including role transition, is the ability of the person to undergo adaptation, that is, adapt to their changing situation.

ADAPTATION

Adaptation, as part of human development, is defined broadly by several authors (Anderson et al., 2011; Higgins, Loeb, & Ruble, 1995; Pollock, 2013; Schlossberg, 1981), though predominantly adaptation is broken down into specific component aspects. Pollock (2013) defines contextual adaptation as part of human functioning, as a process that incorporates the integrations of self, an individual's personal experience and sociocultural demand. Higgins and colleagues (1995) broadly define adaptation as a means of making fit, usually by modification. Schlossberg (1981) asserts adaptation is a main component of transition and two types of adaptation have been identified, *cognitive adaptation* and *occupational adaptation*. Both are important in transition from a forensic psychiatric hospital to the community. Life on a hospital ward is very different from the demands and reality of the outside world. Leaving the support and structure of the hospital ward, managing budgets, and adapting to new accommodation are just a few of the transitions those leaving the hospital ward must make that can be demanding (Nolan, Bradley, & Brimblecombe, 2011). Transitioning from a hospital ward environment to the community requires an individual to be aware of the changes occurring and how they think and feel about it, along with being able to adapt the ways of doing a task.

Taylor (1983) developed a theory of cognitive adaptation which is useful when considering forensic psychiatric transitions. Looking for meaning within an experience helps individuals to restructure their life to incorporate the change. An individual then moves through an adjustment period as a way of developing a belief they are capable of determining their outcome. This cognitive adaptation process is an attempt by individuals to increase their sense of self. Cognitive adaptation theory views individuals as adaptable, self-protective and able to function in times of setbacks and transition. Often an individual will either return to or even exceed previous psychological functioning (Taylor, 1983).

Blair (2000) contends engagement in, and the personal meaning of, occupations³ has been found to be central to life's transitions. *Occupational adaptation*, as defined by Frank (1996) is the ability to adapt an occupation to fit the needs of an individual. There are many reasons, including transitions, which require an individual to alter established habits and routines and the way they would normally complete occupations (Blair, 2000; Frank, 1996). Scalzo, Forwell, and Suto (2016) explain that during times of transition, individuals have opportunities to explore what may succeed in their new reality, making changes and modifications where necessary and reducing disorder and uncertainty during this time of what is often chaos. For forensic psychiatric clients, everyday occupations, such as cooking meals and when to eat them, meeting family and friends and managing home and flat maintenance, are completed in very structured and monitored ways within the hospital ward environment. Thus, clients often need to relearn how to complete these occupations during their transition to the community, after many years in hospital. What enables a person to adapt their pattern of thinking or to adapt how they complete their occupations are the use of a range of internal and external features. The features have been developed and fostered over the course of a person's lifetime and will influence how an individual processes their transition. These features are regarded as important because they are used in the frameworks and models of transition that will be reviewed in the next chapter.

INTERNAL AND EXTERNAL FEATURES OF TRANSITION

Anderson and colleagues (2011) contend transitions are influenced positively or negatively depending on whether the individual has the capacity to draw on a range of personal attributes. The success of transition is often dependent on these attributes/factors: both internal and/or external to the individual, working together. The following seven features, agency, coping strategies, meaning-making, self-determination, self-efficacy, self-identity, and support, have been identified within literature as being important in transition processes. These features are not presented in a hierarchical order. Each have the potential to positively or negatively influence the others, each are regarded as important as the others.

³ Occupations are the activities an individual engages in that are meaningful and important to them or are required to complete (Wilcock, 2002)

Agency

Agency provides opportunities for individuals to make decisions about their life allowing an individual to take part in self-renewal, self-development and adaptation in times of change. Agency is an individual's volition or human freedom to make decisions for themselves (Bandura, 2001; Hitlin & Elder, 2007). Schoon (2007) asserts individual agency can both be constrained and afforded during transition.

Hitlin and Elder (2007) believe agency deals with questions of personal causality and is central to the development of self. Dietz and Burns (1992) argue all individuals possess a degree of agency while no individual has unrestricted agency and agency is contextually based. In certain situations, such as in a forensic psychiatric hospital, an individual's ability to exert their agency will be less while in other contexts the individual will have greater influence over the outcome. Billy's ability to exert his agency within the hospital system was limited, though as he moved out of the confines of hospital this agency increased. For successful transition to the community, clients are required to make decisions about whether to take medications, whether to be actively engaged in the upkeep of their homes, to manage finances or to be engaged in a range of activities deemed appropriate by society (Livingston, 2018).

Constraining agency is normal, and Schoon (2007) contends outside events such as political changes, downturn in economic markets and natural disasters all influence an individual's ability to exert their agency. This can be seen acutely within forensic psychiatric services. A pending election or a change of government can influence the decisions of those people in authority about forensic psychiatric client transitions and the individual client is unable to influence them in any way.

van Breda's (2016) research in South Africa discovered when individuals making the transition out of care into independent living could exert their agency they were able to overcome several of the social environment deficits that were present and move ahead in their lives. Personal agency had the potential to have an impact on the social structure in which those individuals making the move lived. The research found being actively engaged in decision-making and believing their voice was heard was shown to be important for individuals in the transition out of care into independent living in the community. Though this research does not include clients from within forensic psychiatric services, several elements are pertinent to this research project, such as the

importance of decision-making, the project's focus on agency, and hearing the voice of the client, which made it appropriate to be in the review. Hearing the voice of the client, and involving clients in decision making can both prove challenging within forensic psychiatric services.

Coping Strategies

Coping with the stress is an important factor in ensuring the success of the transition. Coping is defined by Lazarus and Folkman (1984) as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 141). Each individual will draw on a range of strategies they have in their repertoire as a way of managing the stress and attempting to regain control of the situation (Cooper, 1990; Pearlin & Schooler, 1978). Preyde (2009) claims there are a wide range of ways an individual can cope with stressful situations and individuals will not necessarily use the same strategies for each event. The effectiveness of a strategy will depend on the context in which it is used. One strategy may be deemed as maladaptive in one situation while adaptive in another. For example, walking away from a volatile situation may be viewed as an adaptive coping strategy while walking away from an exam may be viewed as maladaptive. Pearlin and Schooler (1978) suggest methods of coping with stress that an individual will employ are related to the psychological resources they currently possess, their self-esteem and their sense of mastery over a situation. Individuals who can call on a range of coping strategies and have flexibility will most likely handle the stress of transition. Coping is not a fixed trait but rather a dynamic process in constant flux (Anderson et al., 2011).

Heath and Priest (2016) explored the experiences of transition and instability and its impact on coping with young offenders who were within a specialist forensic psychiatric service. The participants all experienced a range of challenging contextual factors including disruptive relationships, inadequate living arrangements, limited supports, and exposure to violence and conflict. They found their participants had limited functional coping strategies. A number could identify positive strategies such as making choices and engaging in hobbies; however, there was a sense that participants would revert to more established patterns of coping in times of stress and

these were regarded as maladaptive, for example, consuming drugs, cutting⁴, aggression and running away. Though this project focused on adolescence there are aspects that are pertinent to my research project. Adults within forensic psychiatric services often have similar maladaptive coping strategies as outlined above. Engaging clients in positive coping strategies will be helpful because transitions create stress for individuals and how that person copes with the stress will have an impact on the success of the transition.

Meaning-Making

Meaning-making has been identified as important in an individual's life when adapting to changes (van den Heuvel, Demerouti, Bakker, & Schaufeli, 2013), such as addressing stressful experiences (Park, 2010), trauma, and mental illness (Noble-Carr, Barker, & McArthur, 2013). van den Heuvel and colleagues (2013) contend meaning-making is the reflective process an individual undertakes in an attempt to make sense out of a life event or situation and attempting to create meaning in a situation is believed to demonstrate an awareness to adapt to change.

The concept of meaning is not easily defined, and Baumeister (1991) proposed "meaning as a shared mental representation of possible relationships among things, events and relationships. Meaning connects things" (p. 15). Taylor (1983) suggests that in an attempt to understand an event and the implications of the situation, individuals will try to find meaning by asking the questions "why did this occur?", "what made this happen?" or "what does this mean for me now?". Humans are meaning-making creatures who can see patterns, make patterns and use patterns. Pryor and Bright (2007) maintain it is through these patterns humans look for meaning and personal significance in the otherwise jumbled sequences that make up our lives. Meaning-making is seen to be important when focusing on stressful life experiences. Meaning-making is viewed as an attempt by an individual to understand an event and the implications of that event in their life.

Park (2010) developed six principles of meaning-making in relation to adapting to life stressors. If successful in the process of meaning-making, then it is likely an individual

⁴Cutting is a form of self-injury when an individual will intentionally make cuts or slices to parts of their person. This is done in a deliberate attempt to destroy their own tissue to avoid emotions which are intolerable to the person (Simpson 2015)

will adjust better to stressful situations or events. For example, moving out of the secure ward was a stressful event for Billy and initially it was not successful. Billy experienced distress and he was unable to incorporate the change into his life and develop a new reality. By staff slowing down Billy's transition and allowing him more time to process the changes this enabled Billy to find meaning within his transition.

Self-Determination

The American Psychological Association Dictionary of Psychology defines self-determination as the "control of one's behaviour by internal convictions and decisions rather than by external demands" (VandenBoss, 2007, p. 829). Wehmeyer and Shogren (2016) define self-determination as the ability of an individual to determine their own destiny or actions that are free from external influence or control. Self-determination does not refer to having control over outcomes or events; rather, it refers to the degree an action an individual takes is self-caused, that is, the degree the behaviour is volitional and agentic. Deci (1980) believes self-determination is developed and either enhanced or eroded throughout an individual's life course. Deci and Ryan (1985) state for an individual to be self-determining they must have choices and the capacity to make choices. Decisions based on reinforcement measures or any other pressures that could coerce an individual or incite them to feel obligated are not regarded as self-determined.

Deci (1980) asserts individuals can make choices about their behaviour based on a range of information that is available to them, both internally and externally. Though individuals' can determine their own existence, this scope is confined by the variety of contexts an individual navigates. Understandably, individuals can believe they have lost their capacity for self-determination because of external mechanisms governing choice and behaviour. The concept of self-determination is an important one for forensic psychiatric clients wanting to move back into the community. Clients are expected to adhere to a variety of conditions and behave in particular ways to ensure they continue to progress. Choices not to follow expectations outlined by their clinical team will negatively impact on their transition and often see a decrease in liberty (Deci & Ryan, 2010). Being self-determined has causal links to positive life outcomes as well as increased quality of life and well-being (Deci & Ryan, 2000; Livingston, 2018; Ng et al., 2012; Ryan & Deci, 2000; Wehmeyer & Shogren, 2016)

Self-Efficacy

Self-efficacy focuses on the capabilities of an individual, thus, perceived self-efficacy is the belief an individual has of their capability to complete a task/activity or behaviour (Bandura, 1997), and their confidence to demonstrate mastery over environmental demands (Jerusalem & Mittag, 1995). Jerusalem and Mittag (1995) contend during times of stress, such as transitioning out of the hospital ward, individuals will use the capabilities they hold to manage the challenges they face. Individuals who have a high sense of their own efficacy will trust they have the capabilities to master a range of environmental demands. When individuals have confidence in their capabilities they tend to view challenges as problems they can overcome rather than threats or uncontrollable events. Experiencing a high level of perceived self-efficacy enables an individual to feel confident, motivated and to realistically judge positive events as being a result of effort and negative events due primarily to external circumstances. Individuals who experience low levels of perceived self-efficacy are prone to anxiety, and self-doubt. As a result, challenges will be evaluated as threats and the individual will have limited confidence when faced with difficult situations. Bandura (1977) claims when individuals experience high levels of perceived self-efficacy they are likely to use a range of coping strategies, persevere with behaviours and expend the required energy needed in an attempt to overcome challenges.

Bandura (1995, 1997) asserts the development of self-efficacy is influenced by an individual's previous experience of mastery, by seeing others achieve success through perseverance, by being encouraged by others to keep going and by how the individual perceives themselves. Focusing on self-efficacy is useful when considering forensic psychiatric clients' transitions because perceived self-efficacy can be low for forensic psychiatric clients. Billy was anxious about his ability to complete a range of everyday tasks such as using the buses and keeping his flat clean. Seeing peers being successful in their transitions, being encouraged by both staff and peers to keep going, and by experiencing positive feelings when he did complete aspects of his transition, all successfully contributed to his sense of mastery.

Self-Identity

Bullock and Trombley (2000) believe the concept of self-identity is traditionally understood as "the relatively stable and enduring sense that individuals have of

themselves” (p. 413). Bullock and Trombley (2000) also state an individual’s identity is constructed through experience and is considered to be fluid. The surrounding socio-cultural environment is thought to have a significant impact on an individual’s identity.

West-Newman and Sullivan (2013) argue the concept of sociology of self, incorporates how an individual places themselves in their world. Though an individual demonstrates what they believe is their unique identity, it is also a product of social construction. The self is essentially a social structure and it is developed through social experience. According to Mead (1934), a sense of self would be difficult to construct if we lived a completely solitary life; it is through conversations and doing with others that we learn about what we are going to say and do. Hitlin and Elder (2007) considers “the self” constitutes active, socialised, meaning-making individuals. The self is an organised and interactive system of thoughts, feelings, identities and motives. Northcote (2006) believes transition is a key time when the construction of self-identity can be influenced. Successful transitions will also have elements of a rite of passage for individuals, which supports further construction of their self-identity. Returning to the community was an opportunity for Billy to reconstruct how he saw himself. Through engagement in activities and roles and interaction with others, Billy had begun to see himself as a different person from who he was.

Support

Social support has been identified as being crucial and key for handling life stressors. It can provide a buffer for an individual from the effects of stress and strain associated with transitions (Anderson et al., 2011; Kahn & Antonucci, 1980). Connections to others is an important aspect in living a healthy life (Livingston, 2018).

Social support can be broadly categorised into four main areas, intimate relationships, family, friends and professionals (Anderson et al., 2011). Intimate relationships, as defined by Lowenthal and Weiss (1976) refer to those relationships that are reciprocal and involve trust, are understanding, and share confidences and support. Lowenthal and Weiss (1976) found during difficult life events individuals who had experienced intimate relationships in the past, romantic or otherwise, were able to draw on the experience from those relationships and it sustained hope for their future. An experience of an intimate relationship was found to be a resource for support. Intimate

relationships can be lacking for clients within forensic psychiatric services. Because of difficulties forming relationships, many have not had this experience.

Family is a second important resource of support during life transitions for individuals because family members can ease the process of adaptation, and families themselves will adapt to incorporate changes within one of their family members (Anderson et al., 2011). Askola and colleagues (2017) advise that parents of clients within forensic psychiatric services often take a prominent role in supporting their child and take an active role in the planning and preparation of their child moving out of hospital, which we saw in Billy's transition. However, for other clients, because of their history of violence within their family, coupled with a lack of support by external agencies for the family, the family has chosen to either reduce their involvement or are no longer involved with the client.

Friends are a third support and Anderson and colleagues (2011) contend networks of friends provide support for individuals during times of change and crises. Friends provide cushioning to the significant changes and impact that can occur from transition. Finally, organisations and professionals are important for many individuals in transition. These groups can provide objective, impartial advice and support, along with access to resources to aid in the adaptation process (Anderson et al., 2011). As seen in Billy's transition, a range of professionals can play a significant role in providing support for forensic psychiatric clients in transition.

Even when the internal and external features discussed are fostered and developed with individuals, at times, transitions may not progress as expected or result in the desired outcome. Transitions can also be impeded by several barriers.

BARRIERS TO TRANSITION

Accessing adequate housing, engaging in education and training, securing stable employment, developing meaningful personal relationships, and maintaining access to children are all important for the success of transitioning to the community for forensic psychiatric clients (Mezey, Youngman, Kretzschmar, & White, 2016; Thornicroft, 2006). At times, however, policies, processes, attitudes and behaviours will have an impact on a client's ability to access some or all these areas, thus create barriers to integrating successfully back into the community.

Stigma and Discrimination

Scambler (2009) views stigma as being regarded as a social process characterised by the rejection, exclusion and/or blame of an individual or group, born out of a judgement by either an individual or group, which is based on the anticipation, perception or experience of an event. An enduring feature of identity relating to a health problem, or health-related condition, can be a basis for the judgement. Thornicroft, Rose, Kassam, and Sartorius (2007) define stigma as a broad term that incorporates problems with attitudes (prejudice), knowledge (ignorance), and behaviour (discrimination). Stuber, Meyer, and Link (2008) believe stigma and the consequences of stigma creates the largest barrier for clients accessing areas fundamental for transition as it often leads to inequality and exclusion.

Goffman (1963) has contributed significantly to the area of stigma. In his work, 'Stigma: Notes on the management of spoiled identity', he describes a stigmatised person as someone who is considered abnormal by society. They do not have social acceptance and continue to strive to be accepted so will attempt to manage their identity as a way of being seen as an acceptable person. Those individuals experiencing stigma can attempt to cover for their stigma. Some will use their stigma as an excuse for not being successful, others may go into hiding, leading to isolation, anxiety and depression while others may turn to similar people for support and understanding (Goffman, 1963). The concept of stigma is considerable for those within forensic psychiatric services. Gunn (2003) contends clients within forensic psychiatric services are the most stigmatised population within health services and Coffey (2012b) maintains forensic psychiatric clients continue to experience stigma after discharge from hospital, making reintegration into the community harder.

When considering stigma what is most commonly thought about is what is known as personal stigma, that is, the personal psychological process that incorporates prejudicial attitudes and discriminatory behaviours (Corrigan et al., 2005), which has been described above. Another form of stigma, structural discrimination, also has the potential to impact on an individual and their transition to the community.

Corrigan, Markowitz, and Watson (2004) contend that structural discrimination occurs at a macrosocial level, which leads to discrimination at an individual level. Broadly, structural stigma is divided into two categories: intentional and unintentional

discrimination. An intentional discrimination includes legislation which will restrict the rights of individuals with mental illness to participate in a range of activities including holding certain employment positions. Individuals are restricted by the label associated with their illness rather than any demonstration they are unable to perform at the level expected in an employment position (Corrigan et al., 2004). Another intentional discrimination example is the media portraying those living with mental illness in a negative light, such as focusing on the unpredictability of mental illness. Many media stories perpetuate the stereotype of mentally ill individuals being dangerous (Corrigan et al., 2004; Corrigan et al., 2005).

Unintentional discrimination includes policies that might hinder the opportunities for those living with mental illness. For example, insurance companies may charge higher premiums in areas with a higher crime rate in a given city or town. The areas with higher crime rates tend to be in the lower socio-economic areas of a given city or town. Individuals living with mental illness tend to live within the lower socio-economic areas of a given city or town because of their financial hardship, and, as a consequence, individuals can find their insurance premiums are high. As a result, individuals may choose not to, or be unable to afford to, to take insurance cover for their personal items and put themselves at risk of further financial hardship (Corrigan et al., 2004).

Forensic psychiatric clients experience both intentional and unintentional structural discrimination. General mental health services often have policies which do not allow forensic psychiatric clients access to the services they provide, thus making it harder for them to locate appropriate accommodation in the community or activities to engage in. Accommodation for forensic psychiatric services is often within the lower socio-economic areas of cities which can be located further away from the amenities they need to access, such as supported employment offices, banks and their clinical team offices. Clients are then financially burdened as they are required to catch buses or use their cars to attend appointments. The main form of discrimination is manifested as labelling.

Labelling

Becker (1963) is regarded as one of the leading figures and authors regarding labelling and deviance theory. In his work “Outsiders: Studies in the sociology of deviance” Becker argued that deviance is socially constructed and then applied to others.

Deviance is a label given to an individual who acts outside the rules and norms which have been determined by the dominant group. Labelling can lead onto a self-fulfilling prophecy. When a person is given a particular deviant label, by society, then they may take on roles and behaviours that live up to that label (Becker, 1963; Slattery, 2003). Lemert (1981) argued that most people have committed deviant acts at one time or other but are not necessarily caught and then publicly labelled. He asserted it is the public labelling and the effects of that labelling on the individual which are the cause of deviance. Lemert (1981) assertions that an individual's behaviour is influenced by the labelling they experience from others has links to Goffman's (1961a) belief that psychiatric patients' behaviour within institutions is dictated by the structure of the institution rather than the individual's mental illness.

Link and Phelan (2001) describe labelling as a social selection process of prominent differences deemed by members of society as being important and the subsequent assignment of labels based on those differences. Stereotyping then attaches negative traits to the labels that are generally assigned to a group. Link and Phelan (2001) claim labelling is a way in which stigma can be manifested. West, Yanos, and Mulay (2014) state the labelling of individuals and groups can often be used to bring about an "us versus them" mentality and to justify any subsequent discrimination. They also believe labelling of individuals has the potential to impact negatively on the self-concept of individuals and is associated with poor outcomes for individuals.

The "forensic psychiatric" label is an inherently different one from others associated with mental health services. It represents dangerousness and criminality and as a result those clients within these services are subject to many stigmas and subsequent discrimination. Livingston and colleagues (2011) explored and compared the reporting of self-stigma between those within forensic psychiatric services and those within general mental health services. Their project used mixed methods and in the qualitative findings they found their forensic psychiatric participants both anticipated and perceived negative social interactions based on their "forensic" label. The participants believed this was additional to the barriers they already experienced because of their mental illness and other economic disadvantages. Mezey and colleagues (2016) completed a study which explored self-reported levels of stigma and discrimination by forensic psychiatric clients and compared them with a non-forensic psychiatric population. They found over half of their total participants had experienced unfair

treatment by neighbours, family members and members of staff and this could be attributed to the forensic psychiatric label. The process of labelling forensic psychiatric clients creates barriers and establishes the view of Otherness of those clients.

Otherness

Otherness or being viewed as an Other are perceptions which have the potential to create barriers for those within forensic psychiatric services transitioning to the community. Lupton (2013) defines Other as “that which is conceptualised as radically different from Self” (p. 173). Lupton (2013) also contends Otherness is a manifestation of stigma and discrimination and is usually the result of observations of behaviours engaged in by an individual that are deemed as strange and even dangerous. Other is viewed as the opposite of what is safe and familiar, which is associated with Self. Warner and Gabe (2004) argue different groups of people are targeted through this binary opposition of Self/Other.

When groups of people are regarded as different from the dominant majority then those people are viewed as risky and stigmatisation and marginalisation results. Individuals who have multiple Otherness factors such as ethnicity, sexual orientation, or mental illness find they have their Otherness reinforced by those factors. Link and Phelan (2001) contend individuals with mental illness are seen as different so social distance is increased. Kemshall (2002) believes Otherness has been seen as a way to explain why feelings of anxiety and fear are associated with mental illness and Kelly and McKenna (2004) argue this is why dominant groups feel threatened.

Kemshall (2002) argues the process of Otherness has been seen to provide social regulation in which separation, control and surveillance of those with mental illness are central. Many of the segregating features of asylums and psychiatric hospitals have transferred to community care. Ensuring a cloak of invisibility and extensive management appear to be the focus of community care, at times, rather than reintegration, in fact, Taylor (1994) and Coffey (2012b) argue mental health clients remain as segregated and alienated within the community as they were in the hospitals from which they have come. Warner and Gabe (2004) believes for those moving into the community they find they never really fit into either group, neither the community nor the hospital. The exclusion faced by forensic psychiatric clients transitioning to the community, could be argued to originate from the social responses of the community

rather than the illness they live with. The social response, that is, the attitudes and structures within society are the bases in which clients are disabled Oliver (1990), thus making their transition into the community challenging.

Despite these very real barriers to transition, living a worthy life in the community, which does not compromise the safety of others, is possible for clients within forensic psychiatric services. Mezey and colleagues (2016) found forensic psychiatric clients tend to be more settled at discharge from the hospital ward because of the legislation they are under which requires longer hospital stays. These clients are then able to undergo intensive rehabilitation which focuses on inclusion and social recovery while in hospital. Mezey and colleagues (2016) also noted that forensic psychiatric clients also tended to be discharged into the community through highly supportive specialist accommodation which provided shelter and protection from stigma and discrimination. The focus in the specialist accommodation was on rehabilitation, social recovery and inclusion, so clients in such accommodation are less likely to encounter fearful responses from members of the public.

How each forensic psychiatric client wants to live their life in the community is unique and to do so incorporates the range of internal and external features of transition already discussed in this chapter. Outcomes, which suggest clients within forensic psychiatric services had successfully transitioned into the community, were identified within the literature, all of which fit within the concept of recovery.

RECOVERY

Recovery is a personal experience and what constitutes recovery for individuals is unique to them. A definition of recovery is provided by Anthony (1993), and it is much more than focusing on recovering from the illness itself. It is deeply personal; it is a way of living a satisfying life that incorporate hopes, dreams and a sense of purpose, and what it looks like is determined by the individual themselves. Drennan and Alred (2013) claim recovery is not viewed as an intervention, an end product, or result, but rather a journey that an individual engages in. Central to recovery is hope and the need for relationships and social inclusion.

Social inclusion has been found to have an important link to being well for those living with mental illness and incorporates being connected to others and having opportunities to engage in a range of social activities (Mezey & Eastman, 2009; Repper & Perkins,

2009). Mezey and Eastman (2009) also maintain an important component of social inclusion is the ability of an individual to make their own choices and have the confidence in their ability to fully engage with the community in which they live. Choices about engaging with others should be that of the individual themselves rather than having it dictated by health professionals because the client is regarded as an expert in their own recovery.

Drennan and Alred (2013) tells us that offender recovery is also an important outcome for those within forensic psychiatric services, for clients both with and without an established criminal identity. It is a subjective experience of coming to terms with having offended, recognising the influence the offending has on their self-identity and looking at what personal qualities may need to change to ensure the risk of future offending is reduced. For some clients, it may mean looking at their established criminal identity and taking responsibility for their offending. This includes acknowledging the harm they have caused, which is often difficult and can at times pose obstacles to their recovery. Individuals are required to explore past attitudes and beliefs and to evaluate them against what those in society would expect. For other clients, it may be about coming to terms with having acted violently though they do not have an established criminal identity and their violent act has been a result of their psychotic illness. Internally processing the fact they do not view themselves as a violent person but have acted violently is a trauma experienced by the person and can be an obstacle to their recovery. Offender recovery is individual, and involves the person attempting to move past the identity bestowed on them by the manner of their offending, such as, established criminal or violent psychotic offender in an attempt to reconfigure their perception of themselves (Drennan & Alred 2013).

Individuals in the community who are living in recovery, including clients within forensic psychiatric services, are engaged in improving their health and well-being. They are living satisfying lives, as determined and directed by them, which is about meeting their potential (Ministry of Health, 2012b). Wand (2015) argues recovery should be a focus on resilience and well-being rather than risk and illness. Forensic psychiatric clients who are living in recovery will be capable of taking opportunities to participate in their community and taking control of the direction of their life. Indicators of recovery include sustaining employment, living in accommodation of their choosing, participating in education, maintaining healthy relationships, having a

social life, and being engaged in their community to a level they feel comfortable with (Boardman, 2011; Drennan & Alred, 2013; Repper & Perkins, 2009). Therefore, components of recovery include well-being, experiencing a sense of belonging, and resilience.

Well-Being

Well-being, as defined by the World Health Organisation (2001) is “a general term encompassing the total universe of human life domains, including physical, mental and social aspects, that make up what can be called a ‘good life’” (p. 211). An individual’s well-being and how it looks is unique and subjective to them, and this fits well with recovery.

Ryff and Singer (2008) outline six key elements of well-being which provide a breadth of wellness for an individual: autonomy and the ability to be self-determining; mastery over the environment and being able to effectively manage oneself in the world in which they live; having the ability to realise one’s potential and continuing to develop it; connections to others, which are close and rewarding relationships; having a purpose, which includes finding meaning in what an individual is doing and having goals to work towards; and acceptance of oneself, looking at oneself in a positive light and accepting what has happened in the past. Forensic psychiatric clients, like Billy, often need support and encouragement to engage in these six key elements. After years of being confined within the hospital ward environment, clients, like Billy can struggle to take a leading role within their own recovery.

Deci and Ryan (2000) have identified three psychological needs as important for health and well-being, these being autonomy, competence and relatedness. Individuals experience autonomy when they can make choices and believe they are central to making their decisions. Individuals experience competence when they experience mastery and effectiveness when engaged in activities/behaviours. Individuals experience relatedness when they experience a sense of connection and belongingness to others. These three psychological needs work together, so when an individual believes they are central to making decisions for themselves, believe they are capable of effectively mastering actions and feel a sense of belonging and connectedness in their social context, their well-being is improved and they are likely to engage in self-determined actions (Ryan & Deci, 2000).

Sense of Belonging

The need to belong appears to be a widespread desire held by individuals that has been explored as far back as Aristotle, who described humans as social animals (Anant, 1966). Belonging was also deemed important by Maslow (1970) as he placed belongingness and love needs as third within his hierarchy of needs, after physiological and safety needs had been met. Belonging has been explored in a range of literature including psychology, education and sociology and is regarded as a multidimensional concept that incorporates a range of factors unique to an individual (Anant, 1966; Antonsich, 2010; Croucher, 2004; Dixon & Durrheim, 2004). Belonging encompasses emotional attachment relating to interactions with others, groups or systems. Feelings of being valued, respected, needed, being important, and being an integral member within groups and communities are all associated with belonging (Anant, 1966; Antonsich, 2010; Carpiano and Hystad 2011; Mahar, Cobigo, & Stuart, 2013; Power 2013; Savage, Bagnall, & Longhurst 2005). When an individual feels valued, respected, needed, and is an integral member of the groups to which they want to belong then an individual is able to live the life they want, one that is meaningful and worth living, and to find a place in which the individual belongs (Antonsich, 2010; hooks, 2008).

Belonging implies reciprocity between an individual and the group they wish to belong to, each partner has something to give and gain from the interaction. Acceptance can come from shared experiences which brings about understanding of behaviours (Guibernau, 2013; Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992; Hall 2009; Mahar et al., 2013). Anant (1966) argues belonging does not infer dependency but rather describes being within a group. An individual who feels they belong would describe others within that group as “us” and “we” rather than “they” and “them”; that individual would see the group as an extension of him or herself, and they would feel as though they were an essential part of the group.

Ross (2002) believes experiencing a sense of community belonging has been strongly related to self-perceived positive health statuses. Ignatieff (1993) contends feeling safe and belonging are intrinsically linked. A person will experience feelings of safety when they experience a sense of belonging and a sense of belonging when they feel safe. Mahar and colleagues (2013) conceptualised belonging by outlining five core

elements associated with a sense of belonging: subjectivity, groundedness, reciprocity, dynamism and self-determination. These core elements are particularly useful when considering what may help a forensic psychiatric client to live the life they want, one that is meaningful and worth living and to find a place in which they belong. As forensic psychiatric clients develop their confidence to engage in the community in which they live they are also required to manage the stress and anxiety that is associated with the transition. When clients can overcome the stress and anxiety they experience and live a life they want for themselves, they are then regarded as having developed resilience.

Resilience

Resilience is regarded as a dynamic process rather than a characteristic trait that can be attributed to an individual (Rutter, 2012a; Tusaie & Dyer, 2004). Rutter (2006) believes resilience can be described as a reduced susceptibility to environmental risks, overcoming stress, and ensuring a good outcome even in the presence of risks. Masten (2001) and Tusaie and Dyer (2004) claim individuals who have managed to demonstrate effective or adequate adaptation in response to adversity are seen to be resilient. Rutter (2012a) posits individuals will have different responses to adversity and stress because of the individualised nature of the positive and negative influences they have.

Increasingly in literature there is evidence to support the belief that individuals undergoing life events that are stressful or regarded as adverse have the potential, under the right conditions, to promote subsequent benefits (Rutter, 2012b; Seery, 2011), that is, as long as the event occurs at a time and in a way that the individual is able to successfully cope with it (Rutter, 1993; Tusaie & Dyer, 2004). Seery (2011) argues experiencing some level of adversity or stress has the ability to help build resilience because it allows an individual to experience mastery and control, which in turn assists mastery and control in future stressful situations. Rutter (2012b) suggests when individuals have opportunities to improve their social confidence and self-efficacy through social experiences, they increase their development of resilience.

The concept of thriving and flourishing has been explored as a way of focusing on the positive. Where resilience refers to an individual returning to a state of similar functioning at pre-adverse condition, thriving refers to an individual returning to a state

which is improved from their original functioning pre-adverse condition. Thriving focuses on positive gains an individual makes in response to overcoming challenges, which in turn sets them up for future challenges (Carver, 1998; Ryff & Singer, 2008).

Resilience has been studied in relation to a range of transitions experienced by individuals (Hatala et al., 2017; Scheper-Hughes, 2008; Tusaie & Dyer, 2004). Wu and colleagues (2013) believe understanding how resilience can be supported and improved is of interest because this will increase the likelihood of success of future transitions. Masten and colleagues (2004) stated at times of transition a window of opportunity to improve adaptive coping strategies is available, especially for those individuals who are heading down a maladaptive pathway, the transition process can be an opportunity for positive change (Masten et al., 2004). For those within forensic psychiatric services, resilience is an important component to consider when exploring recovery and recidivism. Internal protective factors, such as prosocial attitudes and insight, along with external protective factors, such as social support, and location and type of housing, all have the potential to impact on an individual's ability to develop resilience (Fergus & Zimmerman, 2005; Viljoen, Nicholls, Greaves, de Ruiter, & Brink, 2011).

Viljoen and colleagues (2011) explored resilience and community reintegration within female forensic psychiatric clients and found support for the notion of resilience in their project. Women who were regarded as successfully integrated into their community had higher protective factors and were engaged in their recovery. Transitions to the community that result in forensic psychiatric clients engaging in a life worth living which developed resilience do not always occur. Awareness of factors which demonstrate detrimental experiences of transition to the community is important because those factors can eventually lead to clients, like Billy, to become mentally unwell, which can then pose a serious risk to the safety of both the client and the wider community.

DETRIMENTAL EXPERIENCES

When the factors which support recovery, well-being, belonging and resilience are thwarted, negative outcomes can often result, such as diminished engagement, poor performance and reduced well-being (Adams, Little, & Ryan, 2017; Deci, Ryan, & Guay, 2013). Transition experiences which result in social exclusion and/or transition

shock can have detrimental effects on both individuals and the communities in which they are living.

Transition Shock

At times, individuals who undergo a transition process experience a reaction to that process, referred to as transition shock but also understood as reality, cultural and acculturation shock. Transition shock is the immediate response, which can be dramatic, to the process of adaptation required within the transition process (Duchscher, 2009; Furham, 2012; Ivins, Copenhaver, & Koclanes, 2017). Duchscher (2009) argues transition shock is often associated with role transition, and emerges when an individual attempts to adapt from roles that were known to those that are relatively unfamiliar. An important contributing factor to transition shock is the “element of surprise”, which is when an individual believes they are underprepared for the transition.

Duchscher (2009) suggests transition shock can be expressed in a variety of different manners. Emotional expressions include feelings of stress, frustration, discouragement and disillusionment. Physical expressions of transition shock include sleep disturbances, appetite changes, physical complaints such as nausea and headaches, and, potentially, mental state changes. Intellectual expressions include reduced cognitive functioning, such as memory issues, reduced concentration and poor problem-solving ability. Finally, sociocultural expressions include changes in relationships with others and reduced self-confidence and self-esteem. These expressions can be associated with inadequate support, both functional and emotional, and a perceived lack of control by the individual during the transition process. Forensic psychiatric clients, like Billy, re-integrating to the community may experience several of these features and, at times, these may be attributed to their illness rather than a reaction to the transition process they are undergoing. Individualised preparation which incorporates the needs of the client appears to be key to ensuring detrimental experiences, such as transition shock, are avoided.

Social Exclusion

Baumeister and Leary (1995) contend human beings are regarded as social beings and as a result much of what individuals do daily is understood to be attempts to satisfy needs for social connection. Definitions for social exclusion are numerous and have

caused contention at times, though authors recognise it is complex. Social exclusion can be attributed to individuals, groups, and larger communities and is associated with poverty, inequality, disadvantage and unemployment (Boardman, 2011; Boardman, Currie, Killaspy, & Mezey, 2010; Burchardt, Le Grand, & Piachaud, 2002; Wright & Stickley, 2013). Social exclusion is regarded as aversive and can lead to multiple psychological and physical issues for those individuals experiencing it, many of whom will experience a lower quality of life (Bowles, 2012; Wesselmann et al., 2016; Yuval-Davis, 2011).

Barry (2002) argues social exclusion and poverty are two distinct phenomena, though there is an undeniable link between the two. An individual's level of income will influence the ability of that person to participate in a range of activities in their community. Those who are homeless are unable to participate in the activities that require them to have a permanent residential address. The cost of public transport or the cost of maintaining a vehicle may stop an individual accessing activities that would promote social relationships or accessing important engagements such as a doctor's appointments. Society generally has normative standards in regard to respectable clothing and those on limited income struggle to achieve these standards. As a result, those individuals can experience social exclusion.

Wesselmann and colleagues (2016) claim two core experiences have been attributed to social exclusion – rejection and ostracism. Rejection is when an individual is explicitly told, or it is implied, that one is not wanted in a given social relationship. Ostracism is when an individual is ignored by another individual or group. Goffman (1963) also describes negative social experiences as being forms of social exclusion, such as stigma and discrimination. Wesselmann and colleagues (2016) assert individuals will perceive themselves to be devaluated by others, whether the others are individuals, groups or the larger community.

Individuals within mental health services, and specifically within forensic psychiatric services, are likely to suffer the consequences of social exclusion (Boardman, 2011; Boardman et al., 2010; Coffey, 2012b; Drennan & Alred, 2013). The social exclusion forensic psychiatric clients experience is often a result of the stigma and discrimination they experience, and the impact on individuals can be devastating. Repper and Perkins (2003) claim the impact of stigma and discrimination for clients within mental health services include loneliness, rejection, harassment and ostracism. Rogers and Pilgrim

(2003) argue labelling and stigma negatively impacts the sense of belonging of clients within forensic psychiatric services. Clients can experience negative effects on their health status because of the cumulative reactions of others, and social rejection is a very real experience for forensic psychiatric clients transitioning into the community.

This chapter has presented the first of the literature review chapters. The next chapter reviews frameworks which can be used to guide and explain the internal adaptation process of transitions for individuals. Generic frameworks are reviewed first and then those within general mental health services, within corrections, and last, within forensic psychiatric services.

3 FRAMEWORKS OF TRANSITION

This two-part chapter begins with a critical review of five generic frameworks⁵ of transition (Selder's Life Transition Framework, Schlossberg's Transition Framework, Van Gennep's Rites of Passage, Bridges' Three-Phase Framework of Transition, and French and Delahaye's Four Phase Framework of Transition). Each of the five generic frameworks provides insight into how a transition is processed for individuals, and some of the frameworks provide insights for professionals on how to support those individuals in transition. These five frameworks reviewed provide insights into transitions over many contexts, though they had been originally developed with a specific context in mind with very little linking or recognition of the existence of other frameworks.

One other framework, used extensively in the thesis, was the Being, Becoming, Belonging framework (Hitch, Pépin, & Stagnitti, 2014a, 2014b; Kidd, 1973; Wilcock, 1998; Yazdani & Bonsaksen, 2017). Though not specifically formulated to provide insights into transitions it has utility when considering forensic psychiatric transitions, especially the complex and multifaceted nature of forensic psychiatric clients transitioning to the community.

Part two of this chapter critically reviews transition literature from specific fields, such as general mental health and corrections, which have a crossover nature with forensic psychiatric services. In general mental health services, transition is not defined but, at times, it is used interchangeably with transfer when referring to general mental health clients returning and re-engaging with the community. At times this transfer has a negative impact on clients. The Transitional Relationship Framework (Forchuk, Jewell, Schofield, Sircelj, & Valledor, 1998) provides guidance for professionals on what helps a client move out of hospital into the community; however, it does not explain the transition process a person goes through as they adapt to living in the community again.

⁵ Within the literature, the words framework and model are, at times, used interchangeably to mean the same thing, that is, to represent the conceptual structure used to explain how transition is processed by an individual. For this thesis, to provide consistency, framework alone will be used.

Multiple factors influence the re-integration of individuals from prisons to the community, including access to appropriate accommodation, developing and maintaining relationships, employment, and desistance from ongoing criminal offending. Two resettlement programmes used in corrections are the Good Lives Model (GLM) (Ward, 2002), and the Pathfinder Programme (Lewis, Maguire, Raynor, Vanstone, & Vennard, 2007).

The transition process used in forensic psychiatric services moving between the hospitals and the community highlights the challenge of re-integrating into the community. For example, transitions are often kept hidden by both staff and clients because of the stigma and discrimination which can be experienced by clients. This process incorporates the development of comprehensive transition plans which include practical issues such as accommodation, support, and employment alongside the management of risk factors. Three forensic psychiatric service frameworks employed (the Progression Ladder (Bjørkly, 2004) Approach, Forensicare Risk Management Kelly, Simmons, & Gregory, (2002) and The Good Lives Model (Ward, 2002)) guiding professionals on what to incorporate into clients' transition plans and how to work alongside individuals as they are making this move, rather than how the client adapts to living in the community again.

Though these frameworks are insightful, little of the literature reviewed provided an explanation of what happens during the transition process undergone by the forensic psychiatric client, that is, how clients adapt to the change of environment when moving from the hospital setting to the community, what influenced the transition experience or what a successful transition would look like. In fact, acknowledgment has been made by a range of authors that there is very little literature available regarding moving forensic psychiatric clients to the community. The focus of past research has been centred on risk and recidivism and very little relates to how this group of people attempts to adapt and transition towards a non-deviant lifestyle (Bjørkly, 2004; Coffey, 2012a; Jamieson, Taylor, & Gibson, 2006; Kaliski, 1997).

PART ONE: GENERIC FRAMEWORKS OF TRANSITION

Selder's Life Transition Framework

Selder (1989) proposed a life transition framework that provides insights into how individuals restructure their reality and resolve uncertainty after undergoing change. The framework was developed to provide health professionals, specifically nurses, insights into what their clients were going through during times of major change. Transition is deemed to be initiated if the disruption experienced requires an individual to reconstruct their existing reality. The transition framework focuses on the bridge that connects the old reality to the new reality in the individual's life. There are four overarching elements to Selders's life transition framework.

First, *restructuring realities* requires an individual to construct a new reality when transition occurs as a way of creating new meanings in their life. When a person fails to recognise their reality has changed then engagement in active living can be compromised. The final outcome a person is striving for after transition is identity constancy. Second, *confronting the circumstance* is the process an individual undergoes as a way of acknowledging disruption has occurred and their previous reality is irreversibly altered. Trigger events precipitate the reviewing of the past and create an awareness of the changed reality, the consequences and the permanency of this changed reality. Trigger events may create an awareness of the irreversibility of the change that has occurred as a result of the disruption. Third, *engaging in the transition* involves participating in behaviours that are seen as normal by society as this will help to reduce the uncertainty experienced by a person. Returning to work, engaging with friends again, wearing fashionable clothes are all examples of this type of behaviour. Normalisation connects a person to their previous reality, which provides reassurance of competence. Barriers, such as illness symptoms and side effects of medication, can inhibit the process of normalisation. Last, *temporal factors* influence the experience of transition because during transition there can be changes to the perception of time. Often during major life transitions a person is unable to acknowledge the present experience will be over at any time in the future, which then may result in a lack of hope. The permanency of the disrupted reality is then reinforced and this allows the person to confront their circumstances. There is not a shared sense of time and space with others who are not undergoing the transition (Selder, 1989).

There were no specific examples where Selder's Life Transition Framework had been used with forensic psychiatric clients undergoing transition, though the framework was developed to be used within health services. Aspects of the framework, however, are useful for my project as the framework provides insights into the process individuals go through when creating new realities and the importance of meaning during this process. It also provides broad understandings of the process, inferring each individual's transition is unique to them. For clients like Billy, reintegrating into the community, after long periods in the hospital ward, means how they see and be in their worlds has changed, and as seen from Billy's transition, the process of creating a new reality can be fraught with challenges. Where Selder's Life Transition Framework focuses on how an individual adapts during major changes, Schlossberg's Transition Framework provides guidance for professionals supporting individuals during life transitions.

Schlossberg's Transition Framework

This transition framework was first developed by Schlossberg (1981, 1984) and provides a systematic framework for those counselling individuals through a variety of transitions, including, job loss, relationship changes and health challenges. The focus of this framework is about providing guidance for professionals who are working with individuals in transition. Transition is not so much a matter of change but the individual's perception of change; transition is defined by the person experiencing it. The transition framework has three major elements, which Anderson and colleagues (2011) have explored further.

First, *approaching transitions* recognises where the transition fits within an individual's life stage or situation as being important, rather than the transition itself (Schlossberg, 1981). The focus is about identifying the impact the change will have on the individual and where the person is in the process, that is, whether they are moving into, moving through or out of the transition. Second, *taking stock of coping resources* focuses on identifying potential resources an individual has as a way of coping with the transition. No two individuals are the same, so an individual's progression through their transition is dependent on the resources they have. An individual's history with similar transitions, their age, socioeconomic status, psychological resources, support network and range of coping strategies all have the potential to influence how their transition will progress. Third, *taking charge* encourages individuals to strengthen their coping

resources as a way of successfully responding to transitions which may be out of the control of the individual (Anderson et al., 2011).

Again, there was no specific use of Schlossberg's transition framework with forensic psychiatric clients who were transitioning to the community. However, this framework may provide useful guidance to those professionals supporting clients in their move to the community. Unfortunately, this framework does not provide insights into how an individual processes this transition. While the Selder's Life Transition Framework and the Schlossberg's Transition Framework require individuals to interact with others or the environment, the next two frameworks, Van Gennep's Rites of Passage and Bridges' Three-Phase Framework of Transition, expect individuals to move through set stages or phases during their transition process, though not necessarily in a linear fashion.

Van Gennep's Rites of Passage

van Gennep (1960) developed a three-phase approach to transition during his work looking at the move to adulthood for Aboriginal men in the early 20th century. This framework for transition still influences current transition thinking in employment, health and social literature (Bridges, 1986; Hudson, 1999; Nortier, 1995). It was during this work van Gennep (1960) coined the phrase "liminality" to mean the disorientation an individual experiences when they are between what was their previous way of being and their new way of being.

Rites of passage was defined by van Gennep (1960) as the rites accompanying any change of place, state, age or social position and all rites of passage or transition are marked by three distinct phases. The initial phase is the *Pre-Liminal Rites (Rites of Separation)*. During this phase, an individual is removed from their social life by breaking with previous social practices and routines. The removal can be either symbolically or physically from their culturally appropriate situation and the breaking of links to the old way of being occurs (van Gennep, 1960). The second phase is the *Liminal Rites (Rites of Transition)*. During this phase, an individual may feel betwixt and between the position they have left behind and the position they have not yet securely adopted. Feelings of confusion often occur. Individuals will undergo culturally appropriate customs and rituals during this phase of "no-man's land" as a way of helping them move through it (Turner, 1969; van Gennep, 1960). The final

phase is the *Post-Liminal Rites (Rites of Incorporation)*. During this phase, an individual will return to their group or community to take up their new position. The individual is now expected to behave in accordance with the new norms and standards of the new position within the cultural group the individual is rejoining (van Genneep, 1960).

This seminal transition framework is useful and has been included because the authors of other stage- and phase-based frameworks draw on aspects of van Genneep's (1960) work within their own interpretations.

Bridges' Three-Phase Framework of Transition

Bridges (1986) originally developed this theory of transition to explain what happens at an individual employee level when organisations make significant changes. This theory aimed to originally provide support and guidance to managers to ensure the organisational changes being made were successfully incorporated into their workers' daily lives. Bridges (2003) later broadened this framework to include a wide range of transitions.

Bridges (1986, 2003) clarified change as being a situational event. Something starts, stops or happens in a different way. Bridges proposed transition as a three-part psychological process that occurs as a way of adapting to the change. Bridges (1986) proposed a three-phase framework of transition, which draws on van Genneep's (1960) Rites of Passage work. The three phases rarely occur as distinct phases and in perfectly defined areas. They do in fact overlap and often occur concurrently (Bridges, 2003).

Phase one begins with *endings*: this is where an individual must let go of the old way of being. The person's current reality is being disrupted and change must occur before transition can begin. It is important an individual grieves for what is lost as a way of working through feelings, thus being in a position to accept change. Phase two is the *neutral zone*: this is the time where a person is often in a confused and unsure state. They are not yet comfortable with the new way of being and are looking for guidance and it is when the psychological readjustment is occurring. One of the greatest difficulties with this phase is predicting when it will be over and the feelings of emptiness. The neutral zone is a rich time for insight but it is the phase that is often overlooked. Often the endings and beginnings are so close that there is no room for the neutral zone. Phase three is the *new beginnings*; an individual has now incorporated

the new way of being into their life. They have developed their new identity. They are now comfortable with whom they have now become. How an individual has begun in the past has the potential to impact on their beginnings in the future (Bridges, 1986, 2003).

This framework has some potential to be useful within the forensic psychiatric population in explaining significant life transitions because it recognises transition impacts on an individual's way of being. However, this framework appears to focus mainly on processing transitions which are not desired by an individual. Transitions like Billy's could be regarded as a significant life transition which impacted on the way Billy viewed his world; however, transitioning to the community from the hospital ward was an adaptation he wanted to make. Where the Bridges Three-Phase Framework of Transition views individuals moving through a series of stages or phases as they process their transition, French and Delahaye's Four-Phase Framework of Transition views individuals moving in a circular fashion as they process their transition. The first phase of the cycle is also the final phase of the cycle, essentially insinuating transition is an ongoing process individuals are continually completing.

French and Delahaye's Four-Phase Framework of Transition

French and Delahaye (1996) developed a four-phase framework of transition, originally focusing on individual organisational transitions. The framework is not about compliance but rather commitment by the individual, it does not assume resistance but rather an individual's selectivity, which is determined by the situation and the individual's experience.

The *Security* phase is characterised by familiar processes, habits and patterns used to achieve past successes. These processes, habits and patterns are developed from the values and beliefs held by individuals, which provide individuals with a sense of control and that in turn provides security. A state of *Anxiety* is entered next, one caused when there is loss of the old familiar patterns and processes are challenged. Some individuals spend a long time on the cusp between security and anxiety. Individuals may need help being guided through this phase. The *Discovery* of new information, skills and behaviours is the next phase. This phase can also be a stage of chaos, with the growing commitment to change and the breakdown of old structures increasing uncertainty, which then causes stress. It is during this chaos that learning occurs which

then influences the development of new values and beliefs. Finally, a phase of *Integration* occurs where new skills, information and behaviours are incorporated and used to develop new processes and practices. This is the action phase of the change process. The new practices, which are built on the individual's new values and beliefs, are integrated into new behaviours. Decision-making is what moves the individual from discovery to integration and ultimately into a new phase of security. There are many choices to be made during the change process and choice is mandatory. Not making a choice is a decision in itself. Reducing the amount of time spent in the discovery phase is facilitated by active decision-making (French & Delahaye, 1996).

Aspects of this framework may provide insights into how forensic psychiatric clients, like Billy, transition, due to its focus on skills and knowledge individuals already have and the necessity for choice and decision-making by those undergoing the transition. Though all the frameworks overviewed had been developed specifically to explain transition, none were useful to be used in their entirety with forensic psychiatric transitions.

Seven other frameworks were located within the literature; however, their usefulness to this project has been regarded as limited. A number of the frameworks were too focused on a specific context such as transition to motherhood, developmental transitions, geographical dislocation or the death of a loved one. Others were difficult to apply to clients who were potentially undergoing multiple transitions within the larger transition of moving to the community from hospital. One further framework has been included in this review. Though not specifically developed with transition as its focus, this framework is useful when considering transitions from forensic psychiatric hospital wards to the community. The Being, Becoming, Belonging framework explores the complexities and multiple dimensions of individuals within their worlds, and has been used within both education and health literature.

BEING, BECOMING, BELONGING

Being, Becoming and Belonging are dimensions that have been included together in a range of literature which can be traced back as far as the 1970s. Kidd (1973) proposed the Being, Becoming, Belonging relationship within education literature. He argued the relationship among these three dimensions was dynamic and did not just happen; rather, the relationship is a result of conscious choices. Being, Becoming, Belonging is

concerned with self-discovery, fulfilment and self-expression, it is about living a life that leads to growing and developing, which includes others (Kidd, 1973). Though Kidd (1973) proposed these three dimensions as being crucial for adult education, the framework has relevance within the broader education sector. For example, the Being, Becoming, Belonging: The Early Years Learning Framework guides practice within early childhood teaching in Australia (Sumsion et al., 2009).

Connecting “Doing” to aspects of the three dimensions of Being, Becoming and Belonging has also occurred within literature. Wilcock (1998) first proposed the intrinsic link between Doing, Being and Becoming when she argued support for the dynamic balance between Doing and Being as central to healthy living. The process of Becoming, whatever the individual deemed as best for them, was dependent on the relationship between Doing and Being. Hitch and colleagues (2014a) elaborated further by clarifying that Doing involves active engagement in personally meaningful occupations. Being is the sense a person has of themselves. Becoming is the continuous development an individual goes through during their lifetime and Belonging is the sense of connections an individual has to people and places. Hitch and colleagues (2014b) contend each of the four dimensions (Being, Becoming, Belonging and Doing) interacts and influences the other dimensions and all are important for health and well-being.

Yazdani and Bonsaksen (2017) connected Doing with the three dimensions of Being, Becoming and Belonging as well, in their development of a framework of occupational wellness. They argue there needs to be congruence between what an individual is Doing and the dimensions of Being, Becoming and Belonging. An individual experiences satisfaction with their life when they are able to focus their Doing over all three dimensions rather than one aspect.

The framework of Being, Becoming, Belonging has potential when considering forensic psychiatric transitions to the community. The framework is dynamic and multilayered so has the possibility of providing insights into how clients within forensic psychiatric services adapt to their changing situations. None of the frameworks overviewed thus far have been specifically developed for mental health clients, let alone forensic psychiatric clients. An understanding of the transitioning experiences of clients within general mental health services may provide insights for those within forensic psychiatric services.

PART TWO: TRANSITIONS IN GENERAL MENTAL HEALTH SERVICES

General mental health services, for this review, include all mental health services which have inpatient wards outside of forensic psychiatric services. Therefore, the literature reviewed has included a wide range of mental health service areas where clients re-integrate back into the community. This section does not include those individuals who live with mental illness but are within prisons. Information relating to their re-integration into the community is included within the correctional service section.

Of literature reviewed for this section, transition is not specifically defined, and at times the words transition and transfer are used interchangeably when referring to clients moving back to the community. Though the literature reviewed alludes to features central to transitions, as described in the previous chapter, these components are not specifically linked to transition theory. Much of the literature focuses on the challenges to re-engaging in the community experienced by individuals and the negative impact of these challenges.

Authors have determined experiencing a sense of belonging to the community, employment, access to appropriate housing, strong support networks and a flexible rehabilitation process as all having strong positive influences on community adjustment for those leaving general adult mental health hospitals (Carling, 1990; Grusky, Tierney, Manderscheid, & Grusky, 1985; Pinkney, Gerber, & Lafave, 1991). Challenges, however, are many.

Challenges to Transition

Pinkney and colleagues (1991) argued moving out of hospital to the community can be a difficult time for a client because the obstacles can be many. Poverty, stigma from living with a mental illness, and the symptoms of their mental illness, are all challenges a person is expected to cope with. Nolan and colleagues (2011) also acknowledged the discharge process can cause concern and stress for some of those returning to the community.

Drury (2008) stated clients face formidable barriers to finding employment, adequate accommodation and developing an appropriate social support network, all of which can impact on the transition to the community. Those being discharged from psychiatric

hospitals run the risk of becoming homeless so ensuring basic needs, such as housing, food and clothing, is a focus for the staff who support them. Discharge into supportive housing is a method used by services in an attempt to address this issue.

Kelly and McKenna (2004) contend the victimisation or perceived victimisation by members of the community can lead to social withdrawal by those living with mental illness. Because of fear of discrimination, those with enduring mental illness may choose not to engage socially within the community. There is a real danger that those moving from hospital will become, or remain, socially isolated because of their status, behaviour or appearance. Often those with enduring mental illness will be housed in the 'difficult to let' areas which are more likely to be the low socio-economic areas of a community. Nolan and colleagues (2011) completed a project exploring psychiatric clients' experiences of disengaging with acute inpatient services after being discharged into the community. They found a number of participants were worried about returning home due to the risk others posed them. Participants identified how landlords, neighbours and the police all posed risks to them while in the community. Loneliness and lack of daily structure and insufficient information about the services in the community were all raised as concerns by discharged participants.

Holley, Hodges, and Jeffers (1998) contend that conflict when reintegrating into the community is common. Clients can have different views from their families and their clinical team regarding the timing of the reintegration, the desired proximity to family members within the community and the level of social support required when moving to the community. Levels of support required in housing can also be an area of conflict, with clients believing they often need a lower level than proposed by clinicians and family members. Hanson and Rapp (1992) believe family members of clients with major mental illness want the basics for their loved one when returning to the community. They want for their family member, a safe and appropriate place to live, and meaningful activity to be involved with. They also would like to be involved in the support of their loved one. Family involvement in this transition process has been found to be important in ensuring the success of the reintegration.

Nolan and colleagues (2011) also found just because a service user successfully copes with the stress and life on the ward does not mean they are able to transfer that knowledge to the community. More emphasis on ensuring the transition from hospital to the community has a focus on the everyday social and economic challenges was

needed. According to Nolan and colleagues (2011), ensuring the inpatient experience is as much about focusing on the future as it is about addressing the problems should be a priority, as well as, having opportunities for debriefing about what they had learnt on the ward prior to discharge. This would help re-integration.

The use of legislation has been posited as an important component for successful reintegration to the community, though this provides challenges for both clients and clinicians. Elbogen and Tomkins (2000) propose the use of therapeutic jurisprudence as a method of successfully integrating a person back into the community. They argue legislation can have therapeutic benefit and propose the use of involuntary outpatient commitment orders when transitioning those out of hospital to the community. Further, they propose two types of involuntary outpatient commitment orders. *Conditional release* is when the individual will only be discharged if he or she agrees to specific criteria, such as remaining drug free and taking medications, and these will be monitored with specific assessments. *Outpatient commitment* expects the individual will engage with specific outpatient services while in the community. Elbogen and Tomkins also argue that it should be the sole role responsibility of the courts, rather than clinicians, to balance public safety versus personal liberty concerns. Understandably, many mental health practitioners are divided about the use of involuntary outpatient commitment orders in transitioning clients to the community (Elbogen & Tomkins, 2000).

Within the New Zealand context, there is provision for compulsory treatment of clients within the community and the legislation used is known as Community Treatment Orders (CTOs). These orders are used in a similar way to how Elbogen and Tomkins (2000) have outlined outpatient commitment orders, where there is an expectation clients will engage with treatment and not engage in illicit drug-taking or alcohol consumption. When clients have demonstrated a lack of compliance with treatment then CTOs are often employed, especially if the client is demonstrating continued risks of harm or are likely to have a severe and rapid relapse (Dawson & Mullen, 2008), as can be seen with forensic psychiatric clients like Billy. Gibbs, Dawson, and Mullen (2006) explored the views of service users, family, and health professionals about the use of community treatment orders and found the majority of service users believed the main purpose of the CTOs was to ensure compliance with medication. The service users did believe the CTOs provided them better access to other treatments, supported

accommodation and care from mental health professionals. The families of the service users viewed the CTOs as providing their loved ones with a supportive structure for their care.

A challenge with the use of CTOs to successful transition, is the potential negative impact the CTOs can have on facilitating shared decision making between the client and the clinician. Shared decision making involves the clinician working with the client to ensure the client is central to decision-making and to nurture the client's capacity to act autonomously and develop their capacity to self-advocate (Knight, Kokanović, Ridge, Brophy, Hill, Johnston-Ataata, & Herrman, 2018). Clinicians can behave in a paternalistic way, making decisions or influencing the decisions a client is making, when they believe the client will make bad decisions and the outcome will be detrimental (Hamann & Heres 2014; Pouncey & Lukens, 2010). The lack of shared decision making can have a negative impact on transition due to the inability of clients to be self-determining and influential in their recovery.

Discharge planning is essential to ensure both continuity of care in the community and successful transition. The transitional relationship framework is an approach health professionals can use to support clients back into the community, though this was not specifically seen used within the forensic psychiatric population.

The Transitional Relationship Framework

The transitional relationship framework, formally the transitional discharge framework, was developed by the Schizophrenia Intensive Treatment inpatient programme after a participatory research project, called "Bridge to Discharge", was completed investigating assisting long-term inpatient clients move from hospital to the community (Forchuk, et al , 1998).

The foundations of this framework are the development of a support system for the client, including professionals, peers and family and the development of interpersonal, community living and problem-solving competencies. Several assumptions are integral to the approach. Health is dependent on interpersonal, intrapersonal and societal systems and all these systems are interdependent (Forchuk et al., 1998; Forchuk et al., 2013).

The transitional relationship framework gives priority to facilitating the staff relationship with each client. One staff member of a team works closely with a person

and other team members are used only as resources and consultants. This method aims to elevate the burden on clients of having to sustain relationships with a large number of staff (Forchuk et al., 1998).

Family relationships are facilitated under the transitional relationship framework. Often when a person has lived with prolonged illness, relationships with family are strained; however, it is often the family who provide emotional, social, spiritual, cultural and practical support. Families are encouraged to be involved in the life of the individual who lives with enduring mental illnesses (Forchuk et al., 1998).

Peers also provide necessary support alongside both professional and family support. Appropriate peer support provides guidance on the building of relationships amongst themselves and with others. Peers can be positive role models in regard to decision-making, problem solving and participation. One of the most important roles a peer can take is that of a friend who can provide a much-needed caring network of support (Forchuk et al., 1998).

Though positive outcomes have been demonstrated in several studies (Reynolds et al., 2004; Vigod et al., 2013) the transitional relationship framework has not been easy to implement in practice. The main difficulties have been in the attempt to change traditional practices and policy (Forchuk et al., 2013). The transitional relationship framework provides guidance to what may help a person move out of hospital into the community. The approach identifies and explains the importance of support from multiple areas; however, this framework does not explain how the person adapts to the move to the community.

The literature reviewed overviews several areas necessary for successful transitions to the community for clients within general mental health services such as support, appropriate accommodation and employment. Unlike my thesis, however, the literature reported little on how a client living with mental illness adapts to living back in the community again.

Forensic psychiatric clients also have the added complication of offending so reviewing literature from within corrections may also provide insights into the transition process under exploration.

LESSONS FROM THE CORRECTIONAL SERVICE LITERATURE

Hoge (2007) claims individuals who successfully transition into the community are less likely to reoffend or place other burdens on society. There are several issues which contribute to the challenge of re-entry, including barriers to obtaining housing and general assistance, alienation from family and communities, stigma and discrimination and reliance on public assistance to ensure continuity of care following release. Lennox and colleagues (2012) contend for those living with enduring mental illness, specialist mental health services involvement should also occur. Research shows this to be poor and not necessarily due to poor time limits.

The person who emerges from prison is more than the product of their experiences. They have been shaped by prison life and understanding this and how it relates to their life course is important (Baron, Draine, & Salzer, 2013; Visser & Travis, 2003). Farrall, Bottoms, and Shapland (2010) claim “An adult offender with two or more convictions, no matter if they have served prison sentences, will have difficulty transitioning to a requalified citizen” (p. 548). This can be due to difficulties with economic factors, such as obtaining and retaining employment, relational factors, such as building relationships after the conviction, and emotional factors, such as learning which social context will be accepting and which will not (Farrall et al., 2010).

Parsons and Warner-Robbins (2002) and Visser and Travis (2003) claim too much focus has been put on recidivism as the outcome measure of re-entry to the community. This has been at the expense of a more complex understanding of the milestones of the reintegration process. Securing and maintaining employment, resolving conflict with family, maintaining sobriety, joining community organisations, mentoring young people, and becoming politically active, are all indicators of successful attachment to the community and are all important factors for the success of transitions (Parsons & Warner-Robbins, 2002; Visser & Travis, 2003). Farrall and colleagues (2010) contend the process of being a recidivist offender involves some degree of social exclusion. Living with a major mental illness with a history of offending, such as some of those within forensic psychiatric services, intensifies the challenge of reintegration.

Resettlement Programmes for Prisoners Returning to the Community

Draine and colleagues (2005) outline the resettlement process as being complex and involving factors and resources for family and the community as well as the individual. It is an interdependent process that requires the individual to willingly act in accordance with specific norms as well as the community's willingness to support the individual's pro-social efforts. Integration into the community is dependent on a resource exchange process where resources flow to and from the individual and the community.

Hucklesby and Wincup (2007) assert there are a wide number of resettlement programmes, some are community based, others are prison based and there are also hybrids of the two. Resettlement programmes vary enormously in what type of services they provide and how they are funded. The ideal framework of resettlement would begin in prison and continue into the community when the individual is released. If programmes only occurred while in prison, the likelihood for relapse on release is increased because of returning to original lifestyles. If the programmes do not begin until the individual is released, then there is an increased risk of that individual never connecting to the services.

Burnett and Maruna (2006) and Hucklesby and Wincup (2007) overview resettlement work which can be based on risk, need or strength; however, resettlement programmes are mostly based on needs-based frameworks. These frameworks acknowledge that prisoners have multiple needs and these can be a barrier to effective resettlement and desistance. Difficulties occur, however, when resettlement only focuses on a single need and this is detrimental to the individual (Hucklesby & Wincup, 2007; Raynor, 2007). Risk-based frameworks assume all prisoners are dangerous and they need to be controlled when released through a series of surveillance strategies. There is little evidence to show these types of programmes work in isolation (Hucklesby & Wincup, 2007; Raynor, 2007). The strength-based framework is a move away from the more traditional framework of resettlement. It focuses on the prisoner having a contribution to society and being useful and purposeful. It gives the prisoner responsibility for others, either financially or in a caring capacity. The strengths paradigm calls for prisoners to make amends and to demonstrate their value to the community by making positive contributions (Burnett & Maruna, 2006). An example of this type of

programme is the Good Lives Model (GLM) (Ward, 2002). Ward and Maruna (2007) argue the focus of this approach is to enable offenders to live a good life and it assists offenders to achieve their chosen goals as well as managing the risks they might pose. The GLM has been applied to work with sex offenders most extensively; however, it is designed to be applied to all types of criminal behaviour. The GLM aims to create a more constructive atmosphere between the individual and the professionals working with them. The GLM incorporates aspects that are of concern to individuals such as relationships and addressing the legitimate safety concerns of the community.

Lewis and colleagues (2007) overviewed the pathfinder programme, which was set up in England and Wales as a way of resettling prisoners into the community. Though this programme is no longer in practice, research completed exploring the results of the programme found positive outcomes for individuals, and a number of key messages were drawn that would be useful for guiding future programmes. Individuals who had post-release contact with any project staff, or community links, were less likely to reoffend. Those individuals that engaged in post-release work were significantly less likely to be reconvicted than those who did not. Individuals who engaged with mentors in voluntary-led schemes were found to do significantly better in the community.

Recommendations for future resettlement programmes included ensuring a continuity of care and work begun in custody with individuals' needs to be followed through in the community (Lewis, et al., 2007). Pre-release work addressing cognitive processing skills and practical problems were central to an effective resettlement strategy in terms of reducing conviction. Ex-prisoners may benefit from contact with people who have more time to pay attention to individual needs and can provide personal and emotional support. Development of personal relationships with offenders, skilled and motivated staff, and a holistic approach when working with individuals was necessary (Lewis et al., 2007). Several key features have been identified as being important to the successful resettlement and desistance of individuals leaving prison to the community.

Desistance

Maruna (2001) argues that the concept of desistance has been linked to the successful reintegration of prisoners into the community. Desistance refers to the long-term abstinence from criminal behaviour by those who have an established pattern of offending in the past. Maguire and Raynor (2006) contend desistance is a difficult and

often lengthy process, it is not a one-off event, and reversals and relapses are common; desistance has been described as a zig-zag rather than a linear process.

Individuals differ greatly in their readiness to contemplate and begin the process of desistance. Readiness can be affected by age, major life events, and physical and social circumstances. These factors interact in a complex fashion making it difficult to both predict and to identify when a person is in a frame of mind receptive to change (Maguire & Raynor, 2006). A key element of desistance is the belief of the offender that he or she has begun to take control of his or her life. Desistance is linked to the agency of the offender because even when options look constrained or desperate choices are still available (Farrall et al., 2010; Maguire & Raynor, 2006).

King (2013) claims motivation and confidence are important factors in desisting from crime. Those offenders who are embedded in criminal contexts are less likely to face opportunities to fulfil new roles and identities, which in turn will not generate the motivation and confidence required to desist. For desistance to occur an individual must distance themselves from their past identity and commit to a different future. If the future the individual envisions is unrealistic, however, then dissatisfaction and relapse is increased. While overcoming social problems is often insufficient on its own to promote desistance it may be necessary to further progress. Farrall and colleagues (2010) and Maguire and Raynor (2006) contend no matter how strong motivation is for desistance this can be undermined if an ex-prisoner faces persistent financial or accommodation problems. As individuals move towards a non-deviant lifestyle individuals often need to develop new skills and capacities appropriate to their new lifestyle, and opportunities to use them appropriately.

Farrall and colleagues (2010) claim social structures are seen to help with desisting from crime. Informal pro-social structures such as a stable partner, obtaining and retaining suitable legal employment and removing oneself from criminal friends can all contribute to desistance from crime. These are examples of a concept known as *knifing off*. Maruna and Roy (2007) define *knifing off* as the removal of opportunities, which can be both positive and negative, and providing structural restrictions on criminal opportunities such as employment and significant relationships. Desisting from crime may in part be about not just giving up a way of life but adopting another more socially aware approach to oneself and one's behaviour (Farrall & Maruna, 2004; Seiter & Kadela, 2003).

Bales and Mears (2008) contend regular visits from friends and relatives received by an individual while in prison are associated with increased likelihood of desistance. When released, social ties may help an individual negotiate the challenges of difficult life transitions. There are many challenges to encouraging visits, prisoners not being close to where their communities are, cost of travel, and the environment in which the visits take place. Employment has been identified as an important element for ensuring successful reintegration into the community for those individuals leaving prison (Baron et al., 2013; Visser et al., 2005).

Employment

Visser and colleagues (2005) argue the structure that employment gives an individual is associated with reduced risk of arrest recidivism; however, research into this area rarely addresses the broader context of how employment is meaningful in terms of community integration. Work has been associated with positive psychosocial outcomes. Many individuals leaving prisons fail to secure legal employment because of a range of factors including low education, drug addiction, social stigma and legal restrictions.

Baron and colleagues (2013) explored work outcomes for those leaving prison who also lived with major mental illness. They found their participants reported the community programmes they had turned to, or been referred to, were only mildly responsive to their needs. Though the participants were grateful for the structure, support and financial assistance, the programmes themselves were less than they hoped for. The non-vocational treatment they received was viewed as minimally effective. Often the recovery houses in which they lived offered little more than shelter and the money received barely sustained the respondents' impoverished lifestyles. Job tenure was limited. Many of the jobs that were secured were unsustainable, and owing to the high rate of jobs in the secondary labour market, job stability was not present. Many of current employment laws actually pushed people back into behaviours which put them at risk of arrest and incarceration.

Many of the elements seen as important for successful resettlement of prisoners into the community are relevant to those being discharged from forensic psychiatric services. The extensive time individuals spend in hospital shapes the person who is moving back into the community. A key difference is that individuals within forensic psychiatric services have had their mental illness diagnosis recognised as either significantly

contributing towards or causing their offending. How a forensic psychiatric client adapts to the community again may have aspects not considered within the prison and corrections literature.

FORENSIC PSYCHIATRY

People in forensic psychiatric services, like the majority of the population, undergo a variety of transitions. Many of these transitions are forced upon them and their perception, often based on reality, is that they have limited control over these processes (Barnao, Ward, & Casey, 2015). Moving to the community from hospital is one of the transitions the majority of clients will eventually complete and, after lengthy stays in hospital, is challenging for the majority of those making this transition (Coffey, 2012b; Grusky et al., 1985).

Coffey (2012a) asserts that, more often than not, when discharged, clients within forensic psychiatric services have conditions placed upon them that include abstinence from recreational drugs and alcohol, attendance at appointments, engagement with therapy, and structured daytime activity. Those being discharged must negotiate with communities that will often prove unwelcoming. Being given deviant labels, enduring structural violence and attempting to either rebuild, or build for the first time, social support systems are some of the hurdles that discharged individuals must contend with while trying to reintegrate into the community (Coffey, 2012a; Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005; Grusky et al., 1985; Hartwell, 2003).

Skipworth (2005) contends those individuals returning to the community within forensic psychiatric services, who also require close monitoring, are deemed likely to pose a significant risk to the community. Kaliski (1997) argues the longer an individual remains under supervision, though not necessarily in hospital, the better the outcome; supervision has shown to reduce risks against future violence, re-offending and re-admittance to hospital. Surprisingly, however, there are only a few forensic hospitals that consider hospitalisation as the starting point towards future community care. Inadequate preparation for early discharge produces a poorer outcome than long-term hospital admission (Kaliski, 1997). The transitional phase between hospital and the community allows for the building of relationships with community clinical staff and the developing of necessary skills. Hartwell (2003) believes a consequence of release into the community is being forced to adapt to a change in the environment. Stigma

from long-term hospitalisation can make adapting to the less-structured environment of the community difficult.

Coffey (2012a) completed a qualitative research project to tell the story of identity transition that occurred when forensic psychiatric clients left hospital for the community. He found that an understanding of post-discharge adjustment to community life was contingent on displays of meaning and on the identities people constructed. The real difficulties that forensic psychiatric clients face were compounded by not only mental illness not being easily accepted by the community but also how their criminality provoked a wider fear of chaos and dangerousness. As a result, these transitions were often hidden, strategically from public view by workers, families and the person themselves.

Draine and colleagues (2005), in another research project, explored community re-entry by former prisoners with mental illness and found the needs and behaviours of an individual that were previously managed within the prison system followed that person into the community. According to Draine and colleagues (2005), individuals needed additional help structuring their time and managing the stress of the transition, which, if not properly structured and managed led to negative, impulsive behaviour. This would suggest that those returning from prison may also need to build or rebuild work skills, and participate in legal employment, or other meaningful activities. Though the population discussed by Draine and colleagues (2005) was from the prison system, the difficulties they experienced are similar to those moving out of hospital to the community from forensic psychiatric hospitals.

Gerber and colleagues (2003) found that those living with psychiatric disabilities remained poorly integrated into the communities they moved into after discharge from hospital. Living with psychiatric illness was socially isolating from neighbours, with little or minimal social interaction with neighbours compared with those without mental illness. When moving back to the community those who lived with major mental illness often struggled to adjust to life and work in the community, often because that community being less than welcoming.

Livingston (2018) completed a qualitative study exploring the complexity of what success looked like within the forensic mental health system in Canada using both service users' and service providers' perspectives. Three quarters of the service users

lived within the forensic mental health hospitals while the remaining quarter were living in the community. The study determined success should be gauged broader than by reoffending rates alone. Success was regarded as a dynamic process rather than a static end product. Success for each individual was unique and it manifested in different ways. According to Livingston (2018), success incorporated six domains: living a normal life, that is, living within the normative rules and expectations of society, such as having a job, living in appropriate accommodation and contributing to society; living an independent life, which incorporates living an autonomous and self-determining life, such as, paying bills, managing medications and staying in the community; living a compliant life which followed the rules and expectations of those in authority; living a healthy life, which was about maintaining mental and physical well-being, and connections to others; living a meaningful life incorporated seeing a reason for getting up each day and having purpose within it; and last, living a progressing life, which focused on improving the life circumstances of each individual. Each of these success domains incorporated the principles of recovery, resilience and desistance.

The process of discharging clients to the community begins with the development of transition plans used to provide structure when moving clients out of hospital.

Transition Plans

Kaliski (1997) argues transition depends on a flexible approach and the focus of planning should be on the preparation for practical issues like accommodation, finances, work, transport and access to local support facilities. There is no outcome data to indicate the timetable that transition should follow; however, it seems reasonable that a protracted and gradual process minimises risk. Some individuals who are making this transition may get frustrated by this which in turn may actually increase risk. Transition to the community may be characterised by a cyclic process with re-admissions to hospital regularly occurring; however, a high re-admission rate should not be seen as an indication of failure.

Kaliski (1997) outlines four key areas which should be considered by teams when developing transitions plans for individuals who are moving back to the community. The *personnel* involved in the clinical care of an individual should be stable and made up of a range of professionals, including psychiatrist, psychologist, occupational

therapist, nurses, social worker, and should assume conjoint care during their transition to the community. Poor communication between health professionals poses the most difficulty experienced during this time. The *facilities* should be situated within the hub of the community. The ultimate success of the transition will depend on those in the local community. A graded approach to reintegration to the community is necessary with the use of close supervision which allows for relative freedom to test progress and build confidence. The *programme* followed that provides the structure to the transition process should be as protracted as circumstances allow. Most forensic psychiatric services use an eclectic approach with the progression through a series of steps with eventual reintegration to the community. This gradual approach allows for regular monitoring of functioning, mental state and behaviour. Occupational therapy including life skills training and anxiety management are important aspects to building function for individuals. Finally, *cultural orientation* focuses on ensuring appropriate cultural practices are incorporated, where possible, as this will increase the likelihood of success for individuals.

Lindqvist and Skipworth (2000) believe focusing on the hopes and dreams for the future for the client should be the focus of any preparations for post discharge. The aim is to build a realistic, productive and hopeful future and having the clients' hopes and dreams for the future intrinsically linked to the discharge planning will help ensure success, which is in alignment with an outcome of recovery as discussed by Drennan and Alred (2013). Kelly, Simmons and Gregory (2002) assert the maintenance of a therapeutic alliance has a greater contribution to the reduction of violence than superior skills in risk assessment. The therapeutic relationship underpins all risk assessment and management processes.

Gustafsson and colleagues (2012) completed a qualitative descriptive project, with support workers from within forensic psychiatric services, to explore what aspects influenced clients' rehabilitation through non-institutional forensic psychiatric care. Several factors were identified as influencing the transition process and Gustafsson and colleagues recommended these should be included within care plans for clients during their transition to the community.

Confirming an *accurate diagnosis* for clients was important because this ensured adequate support was provided for individuals. Support workers could then upgrade their skills and knowledge about the individuals' illness and then provide appropriate

input and encouragement that was targeted for the specific client (Gustafsson, Holm, & Flensner, 2012).

Following an accurate diagnosis, focus on ensuring *adherence to medication* was seen to be essential. As part of a client's education it was vital the individual was both aware and understood the importance of uninterrupted drug therapy (Gustafsson et al., 2012).

Education on *illness awareness* for clients enabled them to be actively involved in their recovery. Illness awareness involved the individual gaining knowledge about their diagnosis, including early warning signs and symptoms (Gustafsson et al., 2012).

Drug and alcohol treatment was seen as necessary because it was very common for clients to be readmitted to inpatient services because they had returned to abusing alcohol or other substances when entering the community. A challenge highlighted in this research was finding substance-free homes to discharge clients to (Gustafsson et al., 2012).

Focusing on developing and enhancing the client's *social networks* increased the individual's likelihood of success in their transition to the community. This often proved challenging as the client's social networks had been hurt in the past and both previous friends and relatives did not want contact (Gustafsson et al., 2012).

Engaging clients in *meaningful and purposeful occupation* gave an individual focus. The challenge was finding appropriate and meaningful occupations for the individual to participate in. A lack of enjoyable activities could often lead that client to return to previous alcohol and drug use (Gustafsson et al., 2012).

Locating *secure appropriate accommodation* was regarded as mandatory and housing should be personalised to the needs of the individual. Secure housing in this research project referred to accommodation staffed 24 hours a day, seven days a week. By placing a person in inappropriate housing, the likelihood of that person not being successful in their transition to the community increased (Gustafsson et al., 2012).

A focus on improving *budgeting skills* should be key as it enabled a person to prioritise purchases and manage their bills. Clients' motivation to succeed in their transition often failed if their finances were mismanaged (Gustafsson et al., 2012).

Prioritising *personalising needs* ensured each client's needs were addressed. Difficulties arose when staff made demands of individuals which were outside their capabilities, or if their specific needs had not been understood. Specific education for clients, such as social skills and basic living skills should be included once the client's personalised needs are known. Clear communication was critical during transition to ensure the clinical staff, the client, and the support staff were aware of expectations and who held responsibility (Gustafsson et al., 2012).

Clear plans were developed to cover what was planned during the transition. The plans also outlined the *responsibility delegation*, that is, who had responsibility for the oversight of the transition. The plan also incorporated a *contact person system*, which gave clients information on who and how to contact people in times of crisis and confusion (Gustafsson et al., 2012).

Last, ensuring *regular follow up appointments* was necessary for transition success. It was also important all people in the client's social support network were present at the follow-up appointments. This allowed everyone to hear the same thing and it reinforced what each person responsibilities were (Gustafsson et al., 2012).

Jamieson and colleagues (2006) completed a qualitative research project, with staff from forensic psychiatric services, using grounded theory to explore the pathological dependence to healthy independence for those individuals moving to the community from the forensic psychiatric inpatient services. Their findings assert it is important to focus transition plans on the individual's health and social needs rather than on offending because an individual may appear to be living independently, not offending, not being re-admitted to hospital and complying with all requirements but have no quality of life, no job, low self-esteem or no significant relationship with others (Jamieson et al., 2006).

The studies by Gustafsson and colleagues (2012) and Jamieson and colleagues (2006) focused was on what should occur during the transition process rather than how individuals adapted to living in the community.

Two examples of frameworks used by forensic psychiatric services to help transition clients out of hospital and one framework that has been proposed as useful with this population are now reviewed.

Forensic Psychiatric Frameworks

The *Progression Ladder Approach (ProLad)* (Bjørkly, 2004) is an example of a framework used by a Norwegian forensic psychiatric service to transition clients from hospital to the community; the focus of the approach is to manage the risk of violence clients may be prone to. The approach assumes enhancing functionality and reducing risk are very much related for individuals. An evaluation of the effectiveness of the use of this framework was not found in the literature outside of the author's own work. Eidhammer, Fluttert, and Bjørkly (2014) completed a systematic review of literature focusing on service user involvement in collaboration with nurses regarding structured violence risk management. The ProLad was reviewed and seen as potentially being useful for transition between hospital and the community.

Bjørkly (2004) outlined the ProLad, the framework of which does not provide specific steps to be followed, but rather, four guiding principles to be used when developing the transition plans. First, *existential psychology* assumes human beings have an inborn capacity for personal growth and self-determination. These factors are inherent but how they present can be very different for individuals. The aim is to enhance an individual's self-determination and self-control in a structured and stepwise manner to then reduce their reliance on external factors such as closed doors and close supervision. Second, *behaviour therapy* is used to guide the reinforcing of appropriate behaviours, that is, reinforce alternative behaviours to violence, which also includes individualising coping skills. Third, *cognitive-behavioural* coping strategies based on the stress-vulnerability framework⁶ are used. Individuals identify stressful events and recognise how they may trigger a relapse into violent behaviour. A clear focus on enhancing personal and social adjustment and on relapse prevention is made. The aim is to foster feelings of control and hope. Last, *intensive relapse prevention control* is based on identification of warning signs of coping failure. Clients are encouraged to recognise when their normal coping is not working, some may isolate, others may overact, become physically tense, glower. These ways of coping may all be indicators of violence risk.

⁶The stress-vulnerability framework is one often used for identifying and treating relapses of mental illness (Zubin & Spring, 1977).

The *Forensicare Risk Management Framework*, as overviewed by Kelly and colleagues (2002), is another example of a risk assessment and management framework, used in Victoria, Australia, to support clients who are either moving back into the community or living in the community. There are many types of risks that health professionals are required to identify; these include, but are not limited to, violence to self and others, reckless behaviours, promiscuity, failure to achieve potential, emotional trauma, stress and physical injury. The Forensicare Risk Management Framework provides general guidance on a process to assess and manage risks. No literature was located which evaluated the usefulness of this framework outside of the author's own work (Kelly et al., 2002).

The framework has a three-pronged approach. Firstly, completing a *risk profile* provides contextual circumstances for the client and includes historical illness-related factors and, dispositional factors that have in the past been associated with violence. The risk profile flags key risk indicators and early warning signs. *Risk assessment* refers to the evaluation of when the specific risk may occur. Relapse is expected when working with seriously mentally ill individuals. It is important to understand the relapse patterns for each individual and for this to be incorporated into the person's crisis plan. Risk assessment is more accurate in predicting violence in the short term so it is important the assessment is completed regularly. The risk assessment will determine whether the health professional will need to act to protect the individual or the community. Some clients can identify when they are becoming unwell; however, this ability does depend on level of insight into their illness, treatment, and symptomology they may be experiencing. *Risk management plans* cover what should happen when an individual's risk level is elevated. The plan should be realistic, practical and likely to be effective when needed. Crisis is a normal phenomenon, however, for forensic psychiatric clients, crisis can often have tragic outcomes (Kelly et al., 2002).

Neither of the two frameworks presented explore how the clients themselves process their transition experience. Focus remains on how professionals assess and manage the risks that clients pose to themselves and the community. Though this is important information for professionals supporting forensic psychiatric clients making this transition, this information does not provide insights into how individuals adapt to living in the community again.

The *Good Lives Model (GLM)*, as briefly discussed earlier within the correctional service literature, was developed to support those leaving prison. Barnao, Robertson, and Ward (2010) and Barnao, Ward, and Robertson (2016) proposed this framework as a potential framework to guide practice with forensic psychiatric clients. No literature was sourced evaluating the effectiveness of this framework with the forensic psychiatric population. Barnao, Ward, and Casey (2016) did complete a service users' perception study of the GLM within an inpatient unit and found mixed results; however, the authors still believed the GLM has potential within this population.

Barnao and colleagues (2010) believe the GLM does have potential when working with forensic psychiatric clients transitioning to the community because it puts the client at the centre of decision-making during their transition rather than only focusing on risk reduction of the individual. Clients are viewed as self-determining individuals rather than agents of risk. Having this focus demands health professionals to view the clients as unique, so uncovering what clients want as outcomes and what activities they would like to engage in is central. Rehabilitation is tailored to the individual as a way of ensuring they attain a good life. Robertson, Barnao, and Ward (2011) postulated that focusing on preparing clients with resources, skills, attitudes and values which they need to lead a meaningful and satisfying life which does not inflict harm on others is key. This framework provides guidance for professionals on what to incorporate into clients' transition plans, as a strength-based programme, when supporting clients moving back into the community; however, it does not explain how the individual processes this transition.

Though the focus of the generic frameworks reviewed was on how individuals adapt during transition, no evidence was located within the literature of where the frameworks had been used with a forensic psychiatric population. There were elements from each of the frameworks that could have potential for the forensic psychiatric population transition to the community, though I do not believe any of them could be used in their entirety.

The forensic psychiatric literature did not explain how an individual adapts to moving back into the community. The literature also sparingly used the voice of the client to contribute to the body of knowledge and predominantly refers to the health professionals' view. Challenges are numerous for researchers who attempted to include clients into their research and there has been a call, in literature, to include clients in

future research (Coffey, 2006; Jamieson et al., 2006; Livingston, 2018; Völlm, Foster, Bates, & Huband, 2017). Therefore, a research project that explores how clients transition back into the community, which includes the voice of the client, would be beneficial. The significance of this research is that it will provide insights into the many factors that influence a person's adaptation to life in the community after time in a forensic psychiatric hospital.

As argued by George (1993) earlier, frameworks explaining the experience of transitions are dependent on the specific context in which the transitions are occurring. The next chapter overviews the unique features of the forensic psychiatric service which they influence and have an impact on the transition from hospital to the community for clients within the service.

4

THE HISTORY OF FORENSIC PSYCHIATRIC SERVICES

It was during a landmark case in 1843 after Daniel McNaughton shot Edmund Drummond when *mens rea*, or the concept of an evil mind having to be present for criminal liability, became clear (Hess 2010). Forshaw (2008) clarified that during this time an understanding of criminal liability evolved as a result of increasing knowledge around mental illness and how mental illness may influence an individual's intent to commit a crime. A belief that the presence of mental illness may somehow clear an individual of being morally responsible for their actions developed. A guilty person must have an evil mind; however, their mind must also be free of mental illness or defect. Hess (2010) described that it was during this case when the belief that delusional disorders may well rob a person of reason, thus they are unable would have an inability to form evil intent. The McNaughton Rule was born, which states that each person at the time of an offence is deemed sane. To establish an insanity defence, then, it must be proved that at the time the offence was committed the individual was suffering from a disease of the mind so that they would not know the nature of their crime or that what they were doing was wrong. As a result of this rule those acquitted because of insanity were now to be placed in asylums rather than prisons because recognition was made that care and treatment was needed for those suffering from a disease of the mind (Robertson et al., 2011).

Forensic psychiatric services, globally, were developed to provide specialist care for clients, like Billy, who have offended and who are primarily the responsibility of health services rather than the justice system (Gunn, 2003; Robertson et al., 2011; Skipworth & Humberstone, 2002). The clients within these services are understandably deemed by society as dangerous (Gunn, 2003) as they have often offended violently (Skipworth & Humberstone, 2002). van Nieuwenhuizen, Schene, and Koeter (2002) maintain in most Western countries the McNaughton Rule still underpins the insanity defence today, and ensures that those who meet this criterion are cared for in hospital environments and not within the prison system. Therefore, transitions to the community originate from the hospital system rather than the prison system.

DEFINING THE FORENSIC PSYCHIATRIC POPULATION

Clients within the forensic psychiatric service do not share uniform characteristics though they typically live with psychotic⁷ disorders, for example, schizophrenia characterised by persecutory or paranoid delusions, and will frequently have co-morbidity of substance abuse and/or personality disorder and are often poorly responsive to treatment (Robertson et al., 2011; Skipworth & Humberstone, 2002; Thomson, 2000). Those individuals living with schizophrenia will have received this diagnosis after meeting criteria outlined in manuals such as the Diagnostic and Statistical Manual of Mental Manual, fifth edition (DSM-V). It is likely individuals will have displayed abnormalities in one or more of the five domains outlined in the DSM-V, hallucinations, delusions, grossly disorganised or abnormal motor behaviour, thought disorder and negative symptoms (American Psychiatric Association, 2013).

Thomson (2000) argues the majority of individuals living with schizophrenia will not display violent behaviours; however, those within forensic psychiatric services will likely experience delusions of a persecutory nature, some individuals will experience command hallucinations, and these symptoms are likely to be associated with aggression and violence. Other studies, however, have not found an association between violence and command hallucinations (Cheung, Schweitzer, Crowley, & Tuckwell, 1997). Cheung and colleagues (1997) contend negative emotions such as anger, sadness and anxiety brought about from auditory hallucinations or delusions have also been found to have an association with violent behaviour.

The American Psychiatric Association (2013) and Marder and Galderisi (2017) outline other symptoms of schizophrenia include negative symptoms and they contribute substantially to the impact of schizophrenia, though are not associated with violent behaviour, but can have a significant impact on a person's engagement and connection to their daily life. Negative symptoms include diminished emotional expression which is recognised by reduced expression of emotion in the face, reduced intonation of

⁷ A person who is regarded as psychotic is suffering from an illness, condition or disorder which inhibits their ability to tell what is real and what is not. They may have false beliefs about people, situations or things, they may hear or see phenomena others do not and their speech and behaviour can be incoherent and inappropriate for given situations (American Psychiatric Association, 2013).

speech, reduced movements of hands, head and face, all of which are used to provide emotional emphasis to an individual's speech. Avolition is a decrease in self-motivated action. As a result, an individual may sit without engaging in activities such as work or social activities. A reduction in pleasure from activities which would normally produce positive feelings is known as anhedonia. Alogia or poverty of speech refers to diminished speech output as a result of diminished thought processes. Last, asociality refers to the lack of interest in engaging in social interactions. These symptoms can significantly impact an individual's capacity to engage in spontaneous conversation during interviews, in social situations, or engaging in a range of activities including employment opportunities and, therefore, can significantly impact on a client's transition to the community. Forensic psychiatric clients are treated in a variety of environments and these are structured in specific ways to ensure the safety of both the client and the community.

THE STRUCTURE OF FORENSIC PSYCHIATRIC SERVICES

Gunn (2003) outlines the central elements for forensic psychiatric services are risk assessment and management, the use of security, along with long-term care of clients. Forensic psychiatric services are provided within a range of environments, including specialist hospitals, prisons and the community. The level of security within the specialist hospitals vary, including secure, minimum secure and open rehabilitation wards. Internationally, the different levels of security have several features in common. Secure wards have strict procedures regarding safety and security, and a high staff: client ratio. Furthermore, there can be multiple airlocks⁸ on the doors which access the outside world, multiple locked doors within the wards, policies regarding who can access certain areas within the wards and strict procedures regarding identifying and managing potential weapons (Jacques, Spencer, & Gilluley, 2010; Kirby & Pollock, 1995; Lloyd, 1985). Minimum secure wards and open rehabilitation wards have lower levels of security compared with the secure ward. Air locks are removed and the door to the outside world is either locked only at night or left unlocked. The staff:client ratio is reduced, the intensity of daily procedures to assess risk of violence is reduced, and those living there are once again able to access areas of the ward such as the kitchen

⁸ Airlocks are safety mechanisms stopping clients within secure wards from leaving the ward when they wish.

and laundry without needing to get staff to unlock doors (Nagi & Davies, 2010; Pillay, Oliver, Butler, & Kennedy, 2008). These are the environments forensic psychiatric clients will be transitioning from when they are discharged to the community.

With an increasing emphasis on treating forensic psychiatric clients in the least restrictive environment the development of comprehensive community forensic mental health teams (CFMHTs) has occurred (Edwards, Steed, & Murray, 2002; Mohan, Judge, & Fahy, 2004). Mohan and colleagues (2004) advise these teams are responsible for providing oversight of clients who have moved from the hospital care into the community and still require specialist forensic psychiatric care. The CFMHTs are usually operated with comprehensive liaison between the inpatient wards and the community team. The main functions and roles of the CFMHTs include providing assertive community treatment for clients, assessment and management of risks associated with clients, and providing specialist consultation to other services such as the prisons and general mental health services (Mohan et al., 2004). Skipworth (2005) says to determine whether treatment can safely be delivered outside of a hospital environment, regular and comprehensive assessment of risk (usually towards others) is conducted by the clinical teams.

FOCUS OF TREATMENT

Traverso, Ciappi, and Ferracuti (2000) argue the focus of treatment of clients for clinical teams is not only on their clinical needs but also balanced with society's need for safety. The aims of treatment are to improve an individual's mental state, reducing aggression and challenging behaviour by developing appropriate coping strategies, ongoing risk assessment and management, improving an individual's social functioning, self-care capabilities, self-esteem, and ultimately developing appropriate links in the community. Thomson (2000) outlines that treatment and management of this client population takes a multi-disciplinary⁹ approach. Nursing, social work, occupational therapy, psychiatry and cultural advisers are all actively involved in working alongside individuals in their treatment. Skipworth (2005) believes forensic

⁹ Multi-disciplinary approach is where the specialty skills of each different health professional are used to ensure an integrated team approach when treating clients. The teams are made up of a range of disciplines, including specialist forensic psychiatrists, nursing, occupational therapy, clinical psychology, social work and cultural advisers.

psychiatric services treatment aims to promote rehabilitation. Van Nieuwenhuizen and colleagues (2002) hold the belief that ensuring quality of life for clients detained within forensic psychiatric services, both inpatient and community clients, is a priority. Quality of life concepts should include domains that are important to clients, for example, autonomy¹⁰.

Lindqvist and Skipworth (2000) assert that deliberate rehabilitation should begin within secure wards. It is thought that the long-term risk of a person committing further violent and criminal acts will decrease if rehabilitation begins as soon as possible. However, both researchers and clinicians acknowledge that successful rehabilitation occurs in the least-restrictive environment, where a person is able to reclaim some level of autonomy and gain skills in supporting themselves for their future (Lindqvist & Skipworth, 2000; Skipworth & Humberstone, 2002). A person who has spent time in the secure ward and is now ready for more intensive rehabilitation, but still requires a specialist forensic psychiatric service, may be referred to a minimum secure ward or an open rehabilitation ward. These environments can provide a variety of rehabilitation plans that are tailored to the needs of clients, in a less restrictive environment (Edwards et al., 2002; Nagi & Davies, 2010).

Kaliski (1997) argues that many challenges confront the clinical team when moving an individual from hospital to the community. Needing to treat and return an individual to the community while protecting that community from potential harm often causes conflict for health professionals. Robertson and colleagues (2011) advise health professionals working within forensic psychiatric services can feel pulled in opposing directions where treatment and risk converge into one system. Debates have occurred as to whether the primary focus of treatment within forensic psychiatric services should be addressing the clients distress associated with their mental illness and other psychological needs they may have or reducing the risk of reoffending on discharge. Blackburn (2004) contends health professionals can feel torn between protecting society and treating the client. Disagreement occurs on the amount of emphasis that should be placed on each of these requirements and this can have an impact on how clients transition to the community.

¹⁰ Autonomy is regarded as the ability of an individual to make uncoerced and informed decisions for themselves.

How forensic psychiatric services are structured, both in the physical buildings and the policies and processes which must be followed creates a power imbalance between the client and health professionals.

Power Imbalance

Clients within forensic psychiatric services must negotiate the many apparatuses that are present that exert power and control over their transition. Apparatuses include the legislation clients must adhere to, through to the attitudes and beliefs members of the public have regarding this specific population. Transitioning back to the community is fraught with challenges which staff, and the individuals themselves, are required to negotiate. Foucault (1980) studied the concept of power and his works have a bearing on this project. Dispositif or Apparatus, as translated in English, describes how there are many physical, institutional, attitudinal and knowledge structures in society which aim to both increase and uphold the concept of power within social bodies. These structures aim to control and influence how an individual will behave and how they will engage within their communities. Structures can be tangible, such as buildings and legislation and they can be non-tangible, such as attitudes and beliefs held by individuals and groups within society (Foucault, 1980). Forensic psychiatric clients are familiar with a range of structures that have power over their reality. Legislation, how the physical buildings are designed, societal attitudes about mental illness and criminal behaviour, and their own belief in themselves all have the potential to significantly influence what and how the individual will engage in their world.

Foucault (1977) also developed a social theory called Panopticonism, a metaphor asserting that human populations can be controlled through subtle and often unseen forces. The panopticon was conceptualised to be used within prisons, asylums, schools and factories as a structure where those within the structure could be kept under constant observation and control. In the process of placing individuals in a situation of constant visibility, which is a trap, they begin to internalise the power and control over them so that even when there is no one there to assert the power the individual still conforms, the coercion becomes internalised. The panopticon provokes a sense of being permanently visible, which ensures the functioning of power. An individual is aware they are being observed but will not know exactly where they are being monitored and

as a result suitable behaviours are achieved and individuals begin to monitor themselves (Foucault, 1977).

Constantly being monitored is a fact of life for clients, like Billy, within forensic psychiatric services. They know that random drug testing, medication-level testing and home visits all occur as a way of ensuring they are behaving in the manner expected of them. Forensic psychiatric clients are aware they are being monitored, often by the public, when they are in the community. Any deviation from their plan or being outside of any boundaries they have, then it is likely that information will not only get back to the service but will also make its way to the media. Therefore, it is usually very important to the clients getting closer to leaving hospital that they complete all requirements exactly in the manner they are outlined to ensure there is no negative impact on their increasing liberty.

New Zealand had its own defining moment, in 1988, which saw the introduction of forensic psychiatric services into the country.

FORENSIC PSYCHIATRY IN NEW ZEALAND

Brinded (2000) described that prior to 1988, New Zealand did not have specialist forensic psychiatric services and those who were deemed to be of serious risk to others were usually housed at the National Security Unit at Lake Alice hospital. The National Security Unit was a maximum-security inpatient unit originally developed in 1965 to contain 54 of the most violent psychiatric inpatients in New Zealand. The unit eventually closed in 1999 as part of deinstitutionalisation by which time the regional forensic psychiatric services had commenced (Brinded, 2000; Evans, 2010).

In 1988, a series of adverse events occurred that brought about a Commission of Inquiry which went on to shape the future of forensic psychiatric services in New Zealand. An escalating suicide rate at New Zealand's maximum-secure prison and several homicides committed by psychiatric clients living in the community all led to the government of the day establishing a Commission of Inquiry into secure care in New Zealand. One of the psychiatric clients was an ex-National Security Unit client with a history of serious violence who had been refused admission into hospital and went on to kill two mental health clients at a community mental health facility. The subsequent Mason Report provided the blueprint for the development of forensic

psychiatric services in New Zealand (Brinded, 2000; Evans, 2010; Mason, Ryan, & Bennett, 1988).

The Mason Report (Mason et al., 1988) outlined a series of six principles which guided the development of the regional forensic psychiatric services. First, mentally ill offenders have the same right as non-offenders to access mental health services. Second, mentally ill offenders are the primary responsibility of the health system rather than corrections. Third, a system is required where those mentally ill offenders could be identified at any stage of the criminal justice system. Fourth, cultural understanding is essential for any clinical work and constitutionally mandated. Fifth, a multidisciplinary approach is required including occupational therapy, psychology, social work, nursing along with cultural and spiritual understanding. Last, the integration of security and treatment is necessary and services should place high importance on continued involvement with family/whānau and the client (Evans, 2010; Mason et al., 1988; Simpson, Jones, Evans, & McKenna, 2006).

Brinded (2000) advised that as a consequence of the report five regional psychiatric services were established in the main population centres in New Zealand. Each of the regional forensic psychiatric service were to provide medium- and minimum-security wards, court liaison service, prison liaison, a community forensic psychiatry service and a consultation service to general mental health services. Over the subsequent years forensic psychiatric services have developed rapidly. All regions now offer medium-security wards and most also offer less-secure inpatient wards to which clients can be transferred for further rehabilitation before being transitioned to the community (Brinded, 2000). Skipworth and Humberstone (2002) explain clients accessing forensic psychiatric services in New Zealand must have a mental illness diagnosis. Services for those with personality disorders or for those who are regarded as sex offenders are not the core focus in New Zealand unless they have a co-morbid mental illness diagnosis. These groups of clients are overseen primarily by the corrections department. Evans (2010) explains this set-up is similar to that of the United Kingdom; however, there are two clear differences, the cultural environment and the legislative environment.

The Cultural Environment

The Mason Report paid specific attention to cultural issues, ensuring that the provision of facilities and delivery of healthcare for Māori were addressed. As a result, forensic

psychiatric services in New Zealand were required to reflect the principles of the Treaty of Waitangi¹¹, New Zealand's foundation document. Knowledge of the Treaty and its application in the delivery of mental health services and specifically forensic psychiatric services has been deemed vital within New Zealand (Brinded, 2000; Wyeth, Derrett, Hokowhitu, Hall, & Langley, 2010). Skipworth and Humberstone (2002) state ensuring culturally informed care is provided is necessary within this specialist service to develop therapeutic alignment and to address the disparity of Māori, who are disproportionately represented within forensic psychiatric services compared with their 16% representation within New Zealand's population (Statistics New Zealand, 2017). They are approximately 50% of the prison and forensic psychiatric population (Department of Corrections, 2017; Durie, 1998; Skipworth, Brinded, Chaplow, & Frampton, 2006). Skipworth and Humberstone (2002) suggested the reasons for this disproportion are complex and multifaceted. Links have been made to the impact of colonisation and land loss to reduced health and wellbeing for Māori (Axelsson, Kukutai, & Kippen, 2016; King, Smith, & Gracey, 2009). Therefore, ensuring services are appropriately culturally based aimed to address these disproportionate statistics.

The Legislative Environment

New Zealand has criminal and mental health legislation which govern forensic psychiatric services that are unique to this country. The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH (CAT) 1992) provides the basis for compulsory detention and provides the definition of mental disorder used within mental health services, including forensic psychiatry services. The Act allows for clients to be compulsorily treated in both inpatient (inpatient order) and community (community treatment order) settings. The Act requires consultation with family/whānau, caregivers and specialist cultural advisors such as Māori health workers or Kaumātua¹² where practical unless there is clear clinical reason not to (Evans, 2010; Ministry of Health, 2012a).

The Criminal Procedures (Mentally Impaired Persons) Act 2003 (CP (MIP) 2003) (Ministry of Justice, 2013) is the legislation that is used to deal with mentally impaired

¹¹ The Treaty of Waitangi was signed by Māori chiefs (rangatira) and representatives of the Crown on the 6th February 1840 in Waitangi.

¹² Kaumātua are elders within Māori society who are regarded in high esteem.

persons within the justice system and is designed to work in tandem with the MH (CAT) 1992 (Ministry of Justice, 2013). The CP (MIP) 2003 also provides a range of disposition options for the courts when faced with mentally impaired offenders (Evans, 2010). One of the dispositions available is that of insanity. The M'Naughton rule underpins the insanity legislation in New Zealand. Section twenty-three of the Crimes Act 1961 (Ministry of Justice, 2017) makes a provision for an individual to be not criminally responsible for their actions if they are found to have a disease of the mind which renders them incapable of knowing their actions were morally wrong or they did not know the nature or quality of their actions at the time of the offence (Brinded, 2000).

Brinded (2000) contends once acquitted because of insanity it is likely an individual will then be given Special Patient¹³ status as this tends to be applied to those individuals who pose a significant risk to others, and the community, and on whom special restrictions should apply, and as a result, Special Patients tend to make up the majority of the New Zealand forensic psychiatric services population. Those individuals under this status will have severe restrictions on their access to the community and typically an application for leaves out of the ward, off the hospital grounds, into the community and unescorted leaves must go to individuals, with the relevant authority, outside of the clinical team for approval (Brinded, 2000). The clinical team, who are beginning to develop transition plans for clients, are guided by a document "Special patients and restricted patients: Guidelines for regional forensic mental health services" to ensure all relevant information is provided so approvals can be obtained (Ministry of Health, 2017).

The Minister of Health and individuals in positions delegated by the Ministry of Health play a large part in the granting of increasing leave. This is usually done after considering the recommendations from the clinical team. Each regional area operates a Special Patient Review Group who oversee all those on special patient status along with ex-Special Patients within their region. This group is responsible for monitoring each individual to ensure the movement of those individuals who have been deemed a risk of violence is completed in a clinically appropriate fashion so to ensure the risk to

¹³ The Special Patient status is defined under section two of the MH (CAT) 1992 (Ministry of Health, 2017)

the community is diminished (Brinded, 2000; Ministry of Health, 2017). Therefore, a client transitioning to the community is subject to scrutiny from a range of professionals to ensure the safety of the community and the person themselves.

Forensic psychiatric services are also required to adhere to guidelines which have been developed for all mental health services in New Zealand.

LIVING WELL, PAST 2012

Similar to all areas within mental health services in New Zealand, the forensic psychiatric services are required to follow the directions outlined within the ‘Rising to the challenge: The mental health and addiction service development plan 2012-2017’ (Ministry of Health, 2012b). This document provides a strong vision on guiding the mental health division and is based on the Blueprint II put out by the Mental Health Commission at the end of 2012 (Mental Health Commission, 2012). There are three key principles outlined in both documents which all mental health services should be incorporating into their provision of care. First, the *principle of recovery* refers to living well in the community. Recovery does not refer to the absence of symptoms or returning to previous levels of health. It means an individual can live well despite this. Recovery is an evolving process; hope is central and it stresses self-determination and full participation in a range of activities, services and resources for those living with mental disorders (Mental Health Commission, 2012; Ministry of Health, 2012b). Recovery is covered in greater detail in the following chapter. Second, the *principle of resilience* refers to the ability of an individual to cope under adversity. Mental health services should aid with building capacity in individuals to care for their own mental health (Mental Health Commission, 2012; Ministry of Health, 2012b). Resilience is also covered in greater detail in the following chapter. Last, a *person-directed and person-centred approach* should be incorporated into mental health services. A person-directed approach refers to partnerships between services and service users and their family/whānau. This would then allow for those who are using services to be involved in the shaping and development of services. A person-centred approach refers to ensuring services are focused on a person’s need rather than the needs of those providing services. This approach ensures the principles of recovery are incorporated in every contact with a person and that service users are engaged in the care of their own mental health and wellbeing (Mental Health Commission, 2012).

Gunn (2003) argues that owing to the often intense negative perception held by the public, forensic psychiatric clients are regarded as one of the most stigmatised within any branch of medicine. Skipworth and Humberstone (2002) advised that forensic psychiatric clients are over-represented in a number of negative statistics such as social deprivation and homelessness. As a result, social inclusion has been highlighted as a priority for forensic psychiatric services within the “Rising to the challenge: The mental health and addiction service development plan 2012-2017” document. Services are required to enhance social inclusion opportunities by “providing a seamless transition of care and minimising stigmatisation for people who are leaving forensic mental health services” (Ministry of Health, 2012b, p. 25). Drennan and Alred (2013) attest there are many challenges to overcoming stigma and promoting recovery which health professionals and clients must negotiate. Finding adequate housing, stable employment, meaningful social roles, social networks outside of professionals and access to education are all challenges for individuals and their clinical teams (Drennan & Alred, 2013) and these all can potentially pose challenges to the successful transitioning of an individual to the community.

MOVING BACK TO THE COMMUNITY

Skipworth and Humberstone (2002) contend that transitioning forensic psychiatric clients into the community can be difficult because of the community itself. Often there are barriers are created in an attempt to stop this group of clients moving into specific areas of the community and as a result the clients will have prolonged inpatient admissions though they have been assessed as ready for community reintegration. Lindqvist and Skipworth (2000) argue failures to transition successfully to the community may well be a result of system failure. Exposure, if it happens too quickly, to the new setting and the expectations that go with that setting, coupled with a denial of access to the security and familiarity of the previous treatment environment will increase the likelihood of failure of transition. For many clients, the treatment setting, along with the other clients within that setting, is like home so sudden removal will increase the likelihood of failure.

Successful transitions for those people within forensic psychiatric services into the community are important not only to ensure the safety of the community but also to ensure the individuals themselves have a meaningful and productive life (Gerber et al.,

2003; Gustafsson et al., 2012). Mullen (2000) believes successful transitions to the community and ensuring the long-term viability of community care within forensic psychiatric services is dependent upon allaying the fear and anxiety of both the public and the politicians about the dangerousness of individuals. The fear and anxiety held by society may at times be exaggerated and misplaced; however, it has the capacity to severely influence the progress made towards a less restrictive environment within mental health services.

Assessment and the management of risk to others is one of the fundamental focuses for mental health professionals within forensic psychiatric services (Coffey, 2012b; Doyle, 2011). Keeping the community safe and facilitating the recovery of the person is a balancing act for forensic psychiatric services in Aotearoa/New Zealand (Pouncey & Lukens, 2010; Simpson & Penney, 2011). Lindqvist and Skipworth (2000) claim that forensic psychiatric services are moving from risk assessment to the therapeutics of risk management in an aid to be proactive in supporting their clients in the community. Skipworth (2005) believes there are a number of interested parties that forensic psychiatric clinical teams must consider when making decisions around the timing of reintegration to the community. The views of victims, the wider public, politicians, the client themselves along with their family/whānau all need to be considered. As a result, often lengthy hospital stays can be influenced by not only clinical factors but also by the social environment too. Simpson and colleagues (2006) contend that the lower rates of offending reported for clients of forensic psychiatric services suggests the intensive community follow-up programmes do reduce the risk of violent behaviour for this group.

This chapter has provided a contextual view of forensic psychiatric services, both globally and within New Zealand. This chapter has provided insights into the unique elements of this service, which is part of the social context that the transitions occur within. The following chapter presents the theoretical perspectives and the philosophical underpinnings of the methodological framework, constructivist grounded theory, which was used to develop and undertake the study.

5

METHODOLOGY

This chapter provides a description of the methodology used to undertake this research. I initially start with a discussion of two paradigms used for this research project. I then explain symbolic interactionism and its relevance to the project. After that, I outline constructivist grounded theory, used to guide the data collection and analysis. Next, I provide rationales for the use of semi-structured, intensive interviews and walking interviews as the methods of data collection used for this project. I then consider rigour of the research project and discuss the steps I took to ensure this occurred. Finally, I address reflexivity and discuss the influence my role took in the research project.

Stake (2010) argues all research involves aspects of interpretation; however, interpretive research, such as qualitative research, involves the researcher observing, defining and redefining the meanings of what they hear and see from their participants. Flick (2008) believes qualitative research aims to understand, describe and often explain a social phenomenon from the inside. It aims to explore, from the person or a group perspective, the experience which is being undergone. Charmaz (2014) believes qualitative research has the capacity to provide insights into social justice issues, such as poverty/privilege, equality/inequality and barriers/access at a micro, meso and macro level. Gordon (2012) contends qualitative research is increasingly beginning to feature within forensic psychiatry as it has been identified as having an important role in exploring the complex dynamics that occur within this setting. Gunn (2003) emphasises that clients within forensic psychiatric services are regarded as highly stigmatised, and as a result, social justice issues are pronounced within this population. Therefore, based on these theorists, a qualitative research design was appropriate to use with this study because the aim was to explore the phenomena of transition from the perspective of those involved in the process.

RESEARCH PARADIGMS

This project used a generic definition of paradigm as proposed by Guba (1990). It is broad enough to encompass a range of influences and it is provided in everyday language. According to Guba (1990), a paradigm is defined as “a basic set of beliefs that guides action, whether of the everyday garden variety or action taken in connection

with a disciplined inquiry” (p. 17). Research is informed by the researchers’ beliefs and understandings of ontology, epistemology, theoretical perspective and methodological understandings (Crotty, 1998). The weaving together of these creates the contextual paradigm for the researchers. As such, the researchers’ paradigm will influence and direct how the research is developed, the questions that will be asked and how the data will be interpreted (Carter & Little, 2007; Denzin & Lincoln, 2000). This research project was influenced by two paradigms, constructivism and pragmatism. Neubert (2001) and Reich (2009) both argue that constructivism and pragmatism can be seen as allies, as the number of similarities between them far outweigh the differences. Constructivism is often regarded as the foundation of qualitative research (Denzin & Lincoln, 2000).

Constructivism

Constructivism allows researchers an opportunity to examine in-depth human experience as individuals engage and live within their social worlds. Lincoln, Lynham, and Guba (2018) and Appleton and King (2002) contend constructivism attempts to understand the myriad constructions individuals hold, while attempting to attain a consensus of meaning, all the while, being alert to further information. Creswell (2014) and Patton (2015) argue the goal of research being guided by this paradigm is to rely as much as possible on the people who are experiencing the situation or phenomenon. For this reason, in my study, both the clients’ undergoing the transition into the community and the staff supporting those who are moving into the community were invited to participate in the research. Both groups of participants offered unique, but different, perspectives into this transition process.

Guba and Lincoln’s (1982) five underlying philosophical principles of constructivism guided this project. First, multiple realities are acknowledged as existing side by side; therefore, multiple interpretations could be made. Second, the constructions which emerged from the research were dependent on the meanings that were attributed to them by individuals, therefore, the constructions that emerged from this research project are unique and may never again occur in the same way. Third, generalisations were not expected to be made. The uniqueness of the setting was recognised and valued, which meant that in-depth reporting of the setting was needed so that others could gain insight into an individual’s social reality. Fourth, constructivism allowed

my own knowledge and experience with transition processes and forensic psychiatric services to be recognised and, therefore, as a researcher, objectivity was not expected or seen as possible. Lastly, recognition was made that the values of the researcher and of any involved organisations influenced the research design. Those with the greatest power, such as, the universities and their policies and processes, were expected to have the greater influence in the research process (Appleton & King, 2002; Guba & Lincoln, 1982).

Pragmatism, similar to constructivism, is pluralist in nature (Cornish & Gillespie, 2009; Lupovici, 2009). Pragmatism believes knowledge is grounded in human action and that knowledge is judged on what use it can provide.

Pragmatism

A pragmatist will ask one question before commencing an investigation, “What practical difference would this investigation make?”. This is known as the *so what* principle. If there is no practical difference, then exploration is believed to be pointless (Bryant, 2009; Charmaz, 2014). This was an important question I asked myself before commencing the research. As I was adding the voice of the client and an interpretation of how those clients made this adaptation to the current body of knowledge, I believed this information would provide insights for clinicians and researchers about what the experience was like. Therefore, this research had strong potential to make a practical difference.

The paradigm of pragmatism recognises that the experience a person has is often constrained by the nature of the world they live in, and it also recognises that the world a person lives in is limited by the interpretations they have of their experiences. According to Bryant (2009) and Charmaz (2014), people who describe themselves as pragmatists do not believe in the concept of one main theory of knowledge and reality that is waiting to be discovered; in fact, reality is still in the making and continually evolving for each person. This paradigm recognises multiple ways of knowing, which are not placed in a hierarchy. Knowledge is seen as provisional and not judged on its truth or value but rather the usefulness it can provide (Bryant, 2009; Butt, 2000; Charmaz, 2014; Cornish & Gillespie, 2009). Morgan (2014) suggests the use of pragmatism is increasing in social research, including projects employing exclusively qualitative designs.

Creswell (2014) suggests pragmatism allows the researcher to have freedom of choice when developing the research to ensure the methods, techniques and processes used best suit the purpose of the research. Applied to my own study, pragmatism allowed the inclusion of both staff and clients into the research when exploring the transition process as both points of view are regarded as valid and should be explored. Pragmatism also supported the use of walking interviews with the client participants because this method addressed the power imbalance between researcher and participant and helped to address difficulties with spontaneous conversation which clients with major mental illness can have.

Dewey's pragmatism (Hickman & Alexander, 1998) also influenced this project. Dewey's focus within his pragmatism was about moving philosophy away from abstract concepts and to ensuring an emphasis on human experience occurred; it addresses the question "what is the nature of human experience?" (Morgan, 2014, p. 1048). Dewey outlined a systematic approach to enquiry that he believed is no different between everyday life and research. His approach started with recognising a problem exists. The next step was to consider the variety of ways the problem could be defined. Multiple plans of action to address the problem were then identified and the evaluation of those plans occurred next. Finally, the action that was deemed most likely to address the problem was then carried out (Hickman, Neubert, & Reich, 2009; Morgan, 2014). Through the critical review of the literature I was able to identify the gaps in the current body of knowledge included a lack of explanation about how individuals adapt to living in the community again, and that the voice of the client is used sparingly with forensic psychiatric research. The next step involved me determining how these gaps would be defined and thus, the best way I would be able to work to address the problems. Owing to the lack of knowledge available, I determined this project was one that needed to be exploratory.

Crotty (1998) claims the theoretical perspective is the philosophical stance which informs the methodology of a research project and it provides the context for the research process. The theoretical perspective embodies the way we know what we know. For this project, symbolic interactionism was the theoretical perspective used because both constructivism and pragmatism are embodied within it.

Symbolic Interactionism

Symbolic interactionism is a theoretical perspective associated with constructivist grounded theory and is useful because it is a perspective for viewing social realities and not an explanatory theory that can predict outcomes. It guides a researcher on how to interpret meanings, actions and events. According to Charmaz (2014), symbolic interactionism encourages us to view people as active beings who are engaged in their world and it produces a dynamic understanding of action and events. Symbolic interactionism places great importance on meaning and interpretation as essential human processes. In symbolic interactionism people create shared meaning through their interactions, and those meanings become their reality (Blumer, 1969).

Symbolic interactionism is a perspective for viewing social realities and not an explanatory theory that can predict outcomes. Blumer (1969) believed qualitative inquiry is the only real way of understanding how people perceive, understand and interpret the world. It is only through close contact and direct interaction with people in open-minded, naturalistic inquiry and inductive analysis could the symbolic world of individuals be understood (Blumer, 1969).

Symbolic interactionism produces a dynamic understanding of action and events (Charmaz, 2014). Charmaz (2014) advises symbolic interactionism is a good fit with constructivist grounded theory, as it provides the theoretical perspective while constructivist grounded theory provides the analytic tools to complete the research.

GROUNDED THEORY

Grounded Theory, developed in 1967 by Glaser and Strauss (Hallberg, 2006), aimed to develop substantive theory about important aspects of people's lives that are socially constructed. The research is inductive: the researcher explores the topic with no preconceived ideas to prove or disprove. Constant comparison is used for analysis. Initially, data is compared against other data then data is compared against developing codes and categories (Mills, Bonner, & Francis, 2006).

Since the original 1967 grounded theory studies, there have been many versions of the methodology. Glaserian grounded theory, for example, is regarded as objectivist ontology, and focuses on patterns of behaviour rather than trying to understand meanings participants associate with the social process (Breckenridge, Jones, Elliott, &

Nicol, 2012). Evolved grounded theory has been developed by Strauss and Corbin (Strauss & Corbin, 1990). These authors argue that reality can never truly be known rather it is interpreted. They developed a structured method of analysis and believe the theory generated should be useful to practice (Hallberg, 2006). Constructivist grounded theory, another development of grounded theory, was presented by Charmaz in 1995 as an alternative to the objectivist forms (Charmaz, 2014).

Savin-Baden and Howell Major (2013) believe grounded theory tells a story about the social practices and situations of people. It is used to create a theory to explain a social process. Stanley (2006) argues grounded theory questions focus on process; they are often the “how” and “what” questions. Patton (2015) advises systematic comparative analysis is used to develop a theory which explains what is occurring and this is grounded in the fieldwork. What drew me to this methodology over others was that grounded theory methods do not give details on data collection techniques, but rather focus on the analytic strategies. Strategies of grounded theory include the simultaneous approach of collection and analysis of data (Charmaz, 2000). Researchers gather extensive amounts of rich data, which have traditionally been in the form of interviews. Data collection methods do not need to be limited to this traditional method, so all collection methods are regarded as valid (Bryant, 2013; Charmaz, 2000; Savin-Baden & Howell Major, 2013). Grounded theory gave me the scope to include both staff and clients in the research and to consider a wide range of methods for data collection. It also gave me a clear process for data analysis, which was very helpful as a novice researcher.

Several common characteristics are regarded as being part of all variations of grounded theory (Mills et al., 2006). Data analysis occurs at the same time as data collection so data analysis influences how and what data is collected next. Constant comparisons between what is found at one stage occurs with what is found at the next stage (Bryant, 2009; Hallberg, 2006). Interviewing is regarded as intense and participants are encouraged to reflect and describe a topic to a level they would not do in everyday life. Categories and concepts are generated from the data rather than from preconceived ideas. Detailed memo writing occurs during the entire data analysis process. Data collection continues until theoretical saturation occurs. This is based on a subjective decision and open sampling is used to maximise variation; theoretical sampling should only occur in the later stages (Hallberg, 2006). Theoretical sampling is used to explore

emerging results and is a way in which researchers flesh out and enhance the concepts they have identified in earlier stages of the work. Critics might say theoretical sampling is a way for researchers just to confirm what they initially have found or to try and falsify their work; however, pragmatists view theoretical sampling as a way of researchers seeking out if their concepts work (Bryant, 2009).

According to Breckenridge and colleagues (2012), constructivist grounded theory challenges the belief there is an objective truth that can be uncovered or measured during the research process.

Constructivist Grounded Theory

Charmaz and Bryant (2010) note that constructivist grounded theory assumes the researcher is part of the research process and undertakes a reflexive process. In this process, data is viewed as being co-constructed between the researcher and participants (Charmaz & Bryant, 2010; Hallberg, 2006). This stance sat well with me because of my experience and history of working within forensic psychiatric services. Removing myself or my prior knowledge from the research process was not something I believed I was able to do.

The role and timing of a literature review within grounded theory research is frequently debated and has often been misunderstood (Bryant, 2013; Charmaz, 2014). Charmaz (2014) argues that failing to read adequately prior to the research being conducted runs the risk of rehashing old empirical problems and dismissing the knowledge area in the literature. The main literature review can be completed prior to data analysis; however, the onus is on the researcher to justify the approach being taken to presenting the literature (Bryant, 2013). In my case, I completed a literature review prior to data collection as I felt it was necessary to be able to identify the research gaps and questions before undertaking interviews with this group of participants. I then undertook regular re-reviewing of the literature as the analysis and discussion of the findings progressed.

According to Charmaz (2014), constructivist grounded theory studies the how and why participants construct meanings. The theory developed is seen as being constructed between the researcher and the participant, as opposed to showing itself objectively from the data, as seen in Glasierian and evolved grounded theory. To that end, I used semi-structured, intensive interviews and various types of walking interviews to capture

the participants' view points from their experience of transition.

SEMI-STRUCTURED, INTENSIVE INTERVIEWS

Constructivist grounded theory places priority on the phenomena being studied rather than the methods used to study it. Hence, the methods used to gather data are not prescribed (Charmaz, 2001). This allowed me to think laterally about how best to engage with the participants. I chose non-standardised, intensive interviews, as defined by Charmaz (2014), and these use open-ended questions to allow participants to talk of their own experience and personal knowledge about the phenomena under investigation (Brinkmann, 2018; Richards & Morse, 2013; Taylor & Francis, 2013). This type of interview is used when the researcher wants to learn what is important to the participants or how procedures are understood by them (Richards & Morse, 2013). Therefore, it was an appropriate interview type for this research as it allowed the participants to speak to what they saw as important during their experience of either transitioning to the community or helping develop transition plans and/or supporting those moving out of hospital to live permanently in the community (Taylor & Francis, 2013).

Charmaz (2014) describes intensive interviewing as a flexible technique which enables the researcher and participant to co-construct the interview conversation. This allows participants to share their experience and the meaning they associate with their experience. The researcher listens and observes with sensitivity, encouraging the participant to talk. As a result, the participant does most of the talking in these types of interviews. The walking interviews are a mobile form of semi-structured, intensive interviews.

THE WALKING INTERVIEW

The use of walking interviews¹⁴ (where the researcher walks alongside the participant) as a method of collecting data by social scientists has increased over the past number of

¹⁴ Owing to the emerging nature of the walking interview and the high-risk perception of forensic psychiatric clients, I found minimal literature outlining the use of this data collection method with this population group. I have written two pieces of work which aimed to contribute to this body of work to allow future researchers guidance in using this valuable data collection method. These have been included in full in the

years (Anderson, 2004; Butler & Derrett, 2014; Carpiano, 2009; Clark & Emmel, 2010; Evans & Jones, 2011; Hall, Lashua, & Coffey, 2006; Holton & Riley, 2014; Jones, Bunce, Evans, Gibbs, & Hein, 2008; Kinney, 2017, 2018; Kusenbach, 2003). Though mobile interviewing is still at the infant stage it does show great potential for shedding light on how individuals frame and understand the spaces they use in their lives (Jones et al., 2008). Walking interviews were appropriate to use with the client participants of this research project as I was interested in how the participants connected to the community that they had transitioned to from hospital. Gerber and colleagues (2003) outlined the difficulties forensic psychiatric clients can have in connecting to the community they have moved to from hospital, and using a walking interview allowed me to explore this in greater detail (Kinney, 2017). According to Carpiano (2009), walking interviews are viewed as a more inclusive process (as opposed to the sit-down interview) as they reduce the “power imbalance”, especially in marginalised populations. The interview is regarded as more of a partnership than participant merely being a subject who is being interviewed.

There are several different formats the walking interview can take and are seen on a spectrum from having the route determined by the participant, the route being undetermined, and to the route being completely determined by the interviewer. Each of the walking interviews formats aims to illicit specific information. I explored three walking interviews, the participatory interview, go-along interview, and bimbbling interview, because I believed they were the most appropriate for my study and it turned out all were relevant (Kinney, 2017, 2018). A brief overview of each is provided next, fuller detail can be accessed in Appendix A.

Participatory Walking Interview

The purpose of the participatory walking interview is to gain an understanding of the interviewees’ sense of place and neighbourhood attachment (Clark & Emmel, 2010). This interview takes place while walking around a route that the interviewee has determined which is in their familiar neighbourhood (Clark & Emmel, 2010). The routes used for the participatory walking interview are not considered representative of

appendices (Appendix A). One was published in 2017 and the second was published in 2018. An overview of walking interviews and specifically the types I have used within this research is provided within these publications.

people's actual everyday routines and habits but rather indicative of how the participant thinks about their neighbourhoods (Clark & Emmel, 2010; Emmel & Clark, 2009). I originally believed this type of interview would be the most useful as I was interested in how the area in which participants had selected to walk around was significant in their transition. Though initially I had believed all my walking interviews would be participatory in nature, this did not occur in reality, and were a mixture of all three of the interviews overviewed.

Go-Along Interview

The go-along is regarded as a mix between an interview and participant observation. The natural go-along interview occurs when the interviewer accompanies a participant on an outing that would normally occur. It is important during the go-alongs the interviewer is following participants in their natural environment, completing their normal routines, which are occurring on the usual day, at the usual time and following the usual route they would normally take (Kusenbach, 2003). Carpiano (2009) suggests that in the go-along the participant works as a tour guide, deciding what is important and should be shared with the interviewer. I believed this type was appropriate because it would enable a participant to invite me on an activity they would normally complete. It meant participants would not necessarily have to invent a walk that felt foreign or unnatural to them.

Bimbling Interview

Evans (1998) has described the practice of going for a walk to blow off steam as bimbling, that is, walking or wandering with no clear aim. Bimbling has now been used as a method for collecting data in qualitative research, mainly when exploring activism and when there is a need to move the participant away from an environment which is politicised due to protests taking place (Anderson, 2004; Hein, Evans, & Jones, 2008). This talking while walking interview is conducted in a similar fashion to the other walking interviews; however, the route taken is not necessarily known by either the interviewer or participant. The act of walking provides the opportunity for the participant to recollect experiences and to articulate them (Anderson, 2004) rather than being concerned about the specific location (Jones et al., 2008). This type of walking interview allowed participants to talk spontaneously about their transition,

though I wanted to focus on the location I was walking with the participant through, and the location was not always the focus for the participant.

The reason to clearly articulate the paradigms, theoretical perspective, methodology and the methods of data collection which were used within this research was to allow the quality of the research to be addressed. By clearly stating these the establishment of rigour can be demonstrated so the findings of the project can be viewed as trustworthy.

RIGOUR

Rigour refers to the trustworthiness and authenticity of a qualitative research project (Liamputtong, 2013; Patton, 2015). To establish trustworthiness within this research, I have employed the four criteria suggested by Lincoln and Guba (1985), that of, credibility, transferability, dependability and confirmability.

Credibility refers to the credibility of the researcher. According to Patton (2015), experience, training, status and presentation of self, all contribute to determining the researcher's credibility. Confidence in the researcher leads to confidence in the truth of the data and the researcher's interpretations of that data, which in turn speaks to the credibility of the research project. Credibility is enhanced when the researcher's own experiences are described and interpretations of these experiences are made clear. Self-awareness and the ability to reflect on practice is an essential component for researchers (Graneheim & Lundman, 2004; Koch, 2006). As an emerging researcher, I was very aware of my limited skill and knowledge regarding completing research. Using supervision to explore concerns and issues as they arose and to discuss my data and emerging findings was a very important process to ensuring the project was credible. My supervisors hold a wealth of knowledge and skills and could prompt and focus me when I needed it and were able to challenge any preconceived ideas or thoughts as they arose during our discussions.

Koch (2006) encourages researchers to involve participants in the construction of the findings as a way of enhancing credibility. Member checking was a process I used to help establish credibility (Creswell, 2014). Interviews were transcribed and returned to participants in person. I spent approximately 10 minutes talking through with client participants my interpretations of their interviews. None of the client participants wanted to significantly change my interpretation or remove what they had said. Staff

participants were encouraged to contact me if they wanted to alter any of their interviews. No staff participants requested changes.

Creswell (2014) believes triangulation also establishes credibility. After transcribing and analysing an interview with a client participant, I took my initial analysis to the subsequent interview and checked that I had interpreted accurately and represented their voice. This gave the client participants an opportunity to be actively engaged in the construction of the codes. As a final checking process, I enlisted a panel of experts, made up of individuals who worked within forensic psychiatric services or had previously been within the Aotearoa/New Zealand prison service but who were not associated with the research. I outlined my emerging categories with them, discussing how I had got to the decisions I did. All of those involved with the panel supported the emerging themes as they appeared credible to them. Further detail on this panel is provided within the next chapter.

Lincoln and Guba (1985) note that *Transferability* refers to whether the findings of a research project can fit to another setting, group or context (Graneheim & Lundman, 2004; Koch, 2006; Lincoln & Guba, 1985; Patton, 2015). This can only be determined by the reader if sufficient detail of the context has been provided (Graneheim & Lundman, 2004). Chapter one tells the story of Billy's transition through forensic psychiatric services back to the community. Billy's story is transferable; it is representative of the client's journey within the service experience. The Theorising Transition and Frameworks and Models of Transition chapters provide detail about the phenomena under exploration and the History of Forensic Psychiatric Services chapter details the social context in which the individuals making this move live. This information gives insights into many of the challenges and structures that influence and direct how the transition to the community is progressed. I believe I was able to demonstrate transferability by providing in-depth detail of the unique features of transition for clients within forensic psychiatric services.

Another way to ensure rigour is the instigation of dependability (Lincoln & Guba, 1985). *Dependability* is the degree to which the data changes over time and the modifications to the researcher's decisions during analysis (Graneheim & Lundman, 2004; Koch, 2006; Liamputtong, 2013; Lincoln & Guba, 1985). Koch (2006) believes a decision trail achieves dependability. A decision trail entails providing explicit detail on decisions I made as a researcher on the theoretical, methodological and analytical

choices throughout the research. The process of the research should be clearly documented and traceable for the reader. Clear detail on the methods used within the research are evident (Liamputtong, 2013). Up until now, a decision trail has been visible. The literature review chapters have highlighted the need for the research, by clearly demonstrating the gap that is present in the current body of knowledge. This chapter has described the worldview the research has been developed under. The next chapter provides in-depth detail on the methods used within the research and the process I went through to obtain ethics approval for the project. This will then allow the reader to agree or disagree with the decisions I have made.

Finally, *Confirmability* relates to the neutrality and objectivity of the researcher (Lincoln & Guba, 1985). The interpretations made of the findings should be clearly linked to the data and the experiences and perspectives of the participants and not to preconceived notions, motivations, interests or biases of the researcher (Liamputtong, 2013; Lincoln & Guba, 1985). Details on decision-making and the influences that guided the research should be clear, thus making the entire research transparent. Confirmability is believed to be achieved when credibility, transferability and dependability have been demonstrated (Guba & Lincoln, 1989). I believe I have made clear my decision-making processes throughout the research (chapter six makes explicit the process I followed throughout the study). Measures to ensure any bias or preconceived notions which could have significantly influenced my interpretations have been identified. Moreover, I worked with my supervisors to ensure I remained focused on the perceptions and experiences of my participants. Therefore, I believe I have demonstrated confirmability within this project and at the same time I practised reflexivity.

REFLEXIVITY

Reflexivity can be thought of as self-awareness by a researcher; it is disciplined self-reflection, a process where researchers turn a critical eye to themselves and their practice within the research (Finlay, 2003). Finlay (2002) states “Reflexive analysis in research encompasses continual evaluation of subjective responses, inter-subjective dynamics and the research process itself.” (p. 532). The process of reflexivity is regarded as an important component of qualitative research (Finlay, 2003) and core to constructivist grounded theory (Charmaz, 2001). The quality of the reflexive analysis

depends on the process of how it has been completed. Focus must be maintained on the research participants, with the researchers returning to themselves only as a technique of creating awareness or insight (Finlay, 1998, 2002). Researchers scrutinise their process, experience, ways of knowing and the product of their research (Charmaz, 2001). It is important for researchers to reflect on their background and experiences that have the potential to influence and shape their interpretation and the meaning they assign the data. Reflexivity is more than making clear any biases and values researchers hold but rather making clear how the researchers themselves can shape the direction of the research (Charmaz, 2014; Creswell, 2014).

The position and perspective I brought to this study was influenced by both my professional and personal life. I had worked extensively in the forensic psychiatric service in the past and I brought with me insider knowledge on the transition process. I was also mindful of my previous experience of interviewing clients as a clinician and my previous relationships with many of the staff within the forensic psychiatric service.

I used several strategies which aided me in my reflexive practice. I used a digital recorder as a reflective journal (Charmaz, 2014) enabling me to record my feelings, thoughts and reflections almost immediately after I had completed each interview. The recording helped make explicit what my concerns were and to enable me to recognise what was my opinion and what may have been useful to ask participants in the future. I found this process very helpful as it enabled me an opportunity to work through a number of issues I had identified immediately. I then would re-listen to the recordings a week to ten days later to allow me another opportunity to reflect on the initial responses and feelings I had. I could then question whether these were still significant. This process allowed me to see the potential these feelings had on my interpretation of the data.

As part of my doctoral supervision process I would take concerns I had identified during my reflective journal process and any thoughts or concerns I had identified as part of the rapport building process and discuss with my supervisors the areas I believed may have a significant impact on the research. I wanted to be careful not to attribute meaning that had stemmed from my own experience rather than from the experience of my participants. This process allowed me an opportunity to critically evaluate what I was doing, and how I was doing it. Supervision was an opportunity for

me to engage in discussions about my preconceptions and biases and to ensure I was making these clear to myself (Charmaz, 2014).

This chapter has provided the theoretical and methodological background to the research, and a rationale for the specific data collection methods used has been provided. Additionally, the steps taken to ensure rigour and reflexivity were addressed. The next chapter presents the process I took to complete the research, putting this philosophy and techniques into practice.

6 THE RESEARCH PROCESS

If capturing the voices of the clients in transition was my goal, I needed a methodology that allowed me to emphasise and understand these clients who had poverty of speech. I drew on symbolic interactionism, constructivist grounded theory, semi-structured intensive interviews, and developed novel ideas on walking interviews. Integral to these techniques was the necessity of practising rigour and reflexivity in this technique.

ETHICS APPROVAL

Gaining ethics approval for this project was both complex and in-depth. From my experience I anticipated the ethics committee would regard forensic psychiatric clients as being highly vulnerable and pose a significant risk to others, so, for this reason I began my preparation and consultation process early. My first step was to make contact with the service manager of the regional forensic psychiatric service I wanted to conduct my research through. I presented my initial thoughts and ideas to her and gathered her feedback, which was then incorporated into the design. The service manager then took my research idea to the wider forensic psychiatric service and I received provisional support for the project from them via email (Appendix B).

Because of a high representation of Māori within forensic psychiatric services in Aotearoa/New Zealand it was important that consultation with local Māori occurred prior to the research proposal being fully developed. I did not specifically plan to research Māori; however, I knew from experience the likelihood that a number of the participants would identify as Māori and I had a responsibility under the Treaty of Waitangi to ensure Māori wellbeing was respected and incorporated into the design of the research project (Wyeth et al., 2010). I initially made email contact with the Henare Te Karu, of Te Korowai Atawhai¹⁵ (Appendix B). This service had the responsibility of oversight of Tangata Whaiora¹⁶ within the service. During a subsequent phone call, I discussed my project and I received support from Henare for the project. I also completed the university's Māori consultation process and gained formal support from the Ngai Tahu Research Consultation Committee (Appendix C). The information

¹⁵ Te Korowai Atawhai is the Māori mental health workers service.

¹⁶ Tangata Whaiora is the Māori name for mental health clients

gathered from these consultation processes was then used to develop a research project that met the needs of both the service and the population being researched.

Because the client participants were within the Health and Disability Sector in Aotearoa/New Zealand, I was required to obtain approval through the University's Human (Health) ethics committee. I received an initial response from the ethics committee (Appendix D) advising of areas needing further clarification and I gained final ethics approval in December 2014.

Concurrently, I was required to complete a research approval process through the Specialist Mental Health Service (SMHS) Division, of which the regional forensic service is a part. This required me sending all the same documents that went to the ethics committee to the SMHS Research Committee and I obtained their approval in February 2015. This approval then was sent to the Regional Forensic Psychiatric Service Directorate for formal approval, which was obtained in March 2015, and finally the General Manager of SMHS signed off on the project in April 2015. Once all approvals had been obtained via email (Appendix E) I was able to begin recruitment and the data collection phase of my project and did so in May 2015.

Two amendments to my original ethics approval occurred during the project. Soon after starting data collection the clinical staff from the regional forensic psychiatric service requested the option of allowing hospital-based clients who had begun their transition to the community but were not yet living in the community access to the research project. I believed by allowing this group of clients into the research it would provide further depth and insight into the transition process. Ethics approval was gained in May 2015 (Appendix F).

My second communication with the ethics committee related to widening the pool of potential staff participants. My initial approval covered only staff employed by the regional forensic psychiatric service and during my initial data collection I was introduced to the forensic non-government organisation (NGO) where most of the client participants were living in the community. The forensic NGO¹⁷ was a place

¹⁷ The forensic NGO was situated within the wider community in a suburb that was within a bus ride from the hospital grounds. The forensic NGO was supervised 24 hours a day, seven days a week by community support and peer support workers. The

where many of the clients who were being discharged from hospital went as their initial introduction to living within the community again.

The forensic NGO staff were both interested in the research project and wanted to contribute if possible. I believed they would provide valuable insight into the transition process as they interacted with forensic psychiatric clients daily and had a different perspective of the transition process than forensic psychiatric staff.

Prior to obtaining approval from the university's ethics committee I was required to obtain approval from the forensic NGO. This took several weeks to finalise; however, in September 2015 I received email approval from the wider NGO advising that the staff from the forensic NGO could be invited into the project (Appendix G). I used this email to support my amendment application and I received a letter of approval in October 2015 (Appendix H).

RECRUITMENT

To start recruitment, I initially met with the team leaders of the areas where I planned on recruiting. The team leaders requested I present to the staff the rationale behind the research and to make clear the inclusion criteria I was using. I completed the presentations prior to recruiting either staff or client participants into the project.

forensic NGO was a series of single-storey buildings containing one- and two-bedroom flats that and were attached to each other. To members of the public walking past the forensic NGO, the buildings looked similar to a block of council flats. The buildings were owned by the larger NGO and a number of beds were allocated to the forensic psychiatric clients and were known as the forensic NGO. The beds within the forensic NGO received specialist funding that was ring-fenced only for the clients who occupied those beds. Once a client was transferred out to the wider NGO or an independent flat the specialist funding ceased for that person and they were reliant on the funding that was similar for all specialist mental health service clients. All forensic psychiatric clients who were transferred to the forensic NGO were expected to move on at some point in the future. The forensic NGO was regarded as step-down accommodation that was not permanent. How long each client stayed within the forensic NGO was individualised and was dependent on their circumstances.

Client Participants

Inclusion Criteria

The multidisciplinary teams were asked to discuss and identify potential client participants who met the inclusion criteria and were mentally well enough to participate. Because of my prior history with the regional forensic psychiatric service, it was important potential client participants did not feel coerced or pressured into the research and that they felt safe to decline with no detrimental effects to them. For this reason, case managers approached the clients inviting them into the research. Heyman and colleagues (2013) and Mezey and colleagues (2010) both used this method to recruit patient participants into their respective research projects for the same reasons outlined. Another research project exploring Māori experience of community treatment orders in Otago, New Zealand also used key workers in assessing patients' fitness to participate in the research (Gibbs, Dawson, Forsyth, & Mullen, 2004).

The inclusion criteria for my client participants were the following:

- To have been living in the community for no more than 12 months following discharge from hospital or to be in the process of transitioning to the community from an inpatient ward;
- To remain under the supervision of the regional forensic psychiatric service; and
- To be able to communicate adequately in English.

Potential participants were given a pre-written letter (Appendix I) inviting them to consider participating in the research. The potential participant was asked to let their case manager know if he or she were interested. The case manager then advised me of the contact details of the potential client participant and highlighted the recommended method of making contact. For those clients living in the community this was usually via their cell phone and for those clients still in hospital it was via the ward phone number.

I then made direct contact with potential client participants who lived in the community, arranging the time and place to meet which was convenient to them. I coordinated with hospital staff regarding the availability of the potential client participants who were still in hospital. Once the initial meeting day and time had been confirmed I sent a letter outlining these details to each potential participant and

included an information sheet (Appendix J) to allow them to become familiar with the research prior to meeting with me.

I met with the potential client participant who lived in the community at their own home and at an interview room of the ward for potential client participants who were still in hospital. During the first meeting, the purpose of the research was explained and I reinforced participation was voluntary and not associated with their treatment. All client participants were given a minimum of 24 hours to consider whether they would participate in the research. Two of the client participants requested their first interview commence immediately; however, I advised I would come back after 24 hours to ensure they had time to think about their decision. All clients who met with me proceeded into the research.

During the initial meeting, all client participants were offered a support person to accompany them during the interviews. The support person was to be known to the participant but not part of the client participant's clinical treating team. He or she would provide support to the participant without specifically participating in the interviews. This option was declined by all client participants. All client participants had been identified by their clinical team as suitable to be included in the research project. Each of the client participants were either living in the community or were in the process of moving out of the hospital ward to the community. Therefore, their ability to consent to being part of the research project was deemed as competent by their clinical team.

Immediately prior to the first interview, the consent form (Appendix K) was discussed with the participant and signed. The consent form was reviewed with the client participant again prior to the commencement of subsequent interviews to ensure each participant continued to understand their rights.

Staff Participants

During the presentation to both staff of the regional forensic psychiatric service and the forensic NGO, an invitation to join the research was provided. Copies of an introductory letter (Appendix L) and the information sheet (Appendix M) were left at the services; both documents contained my contact details. Potential staff participants were invited to contact me directly expressing interest in participating. As not all staff were able to be at the presentation I also sent individual emails to each staff member

inviting them to the research, attaching the introductory letter and information sheet after receiving work email addresses from the team leaders.

Inclusion Criteria

To be eligible for the study, staff participants had to meet the following criteria:

- Be involved in the development of plans to help transition those moving to the community,
- Or
- Be supporting those moving to the community while they spend time in both the community and the hospital setting,
- Or
- Be supporting those who live permanently in the community,
- Be able to communicate adequately in English.

After all eight potential staff participants made contact I continued to communicate with them via email. During the first meeting the purpose of the research was explained, and I outlined expectations and reinforced that participation was voluntary and not associated with their employment. The information sheet was given again and staff were encouraged to ask questions relating to the research and the information sheet. All staff members who engaged in this first meeting agreed to be part of the research. Staff participants were invited to participate in one face-to-face interview. Staff participants were given a copy of the consent form (Appendix N) and encouraged to take their time in reading it and only sign if they were happy and had all their questions answered. All staff participants signed the consent form and requested the interview take place immediately after their first meeting with me. The recruitment of staff participants into the research proved difficult and is discussed more fully later in this chapter when Methodological Limitations are discussed.

The forensic psychiatric service, where this research was carried out, was approximately 400 km from where I was based. This created several challenges, especially when attempting to build relationships with staff who were critical to ensuring the successful completion of ethics approval. I attempted to overcome these challenges by ensuring I met with key staff each time I visited the location as a way of developing our relationships.

PROTECTION OF THE PARTICIPANTS

It was important participants of the research were protected from having the contributions they made within the research linked back to them. This was essential to ensure they experienced no negative impact on either their treatment or employment as a result of being a participant of the research.

Many strategies were employed to protect the participants. All interviews were digitally recorded and transcribed in entirety by me. Participants were given the opportunity to choose their own pseudonyms for the research. All the client participants selected pseudonyms unrelated to them. They were advised not to select a nickname they were known by or a name similar to their own. Only one staff participant selected their own pseudonym, the others deferred to me to select a name for them. I am the only person aware of which pseudonym corresponds to each participant and this information has been kept separate from the transcripts. All data was kept electronically on a password-protected computer, which was not linked to the cloud, and hard copies were in a locked filing cabinet.

Anonymity and Confidentiality

Given the nature of the forensic psychiatric services, I was unable to guarantee anonymity for the client participants. As part of the safety and risk management requirements it was necessary for me to have the clinical team recommend client participants for the research and to check in with case managers regarding the mental state of the client participant prior to each interview. Part of the safety and risk management processes of the forensic NGO required me to sign in at the office, advising which client I was visiting prior to meeting with the person. Therefore, the clinical team and the forensic NGO staff were aware which clients were participants in the research.

I was able to offer a level of participant confidentiality. All participants were informed prior to consenting to participating in the research and again prior to commencing each interview the information they gave during the interviews would remain private and would not be passed onto either the client participants clinical team or the staff participants team members or their manager. The client participants were advised that there were two situations when confidentiality may be broken: If they were to disclose

anything that may raise a significant concern for the safety of themselves or another person. If this were to occur, then the interview would cease and I would inform their clinical team immediately. All client participants consented to this. As it turned out, I was not required to disclose any information.

To protect the client and staff participants, and other people associated with them, a number of the personalised details regarding the participants have been removed or changed, within the quotes used within the research, as long as it did not significantly change the meaning of what was being said. All client participants identified as male so male-gendered personal pronouns are used when referring to the client participants. Many of the pseudonyms selected by the client participants are more likely to be associated with males so no changes were made.

Staff participants were a mixture of male and female. Identification of the staff participants may have been possible because of the small number of staff participants within the project. As a result, gender-neutral pseudonyms were chosen for staff participants and random gender allocations were made for each staff participant. The total of males and females equals the actual number in the research. For example, Dale is referred to as male in the research though in reality Dale may have been male or female. This, then, allowed me to use personal pronouns within the quotes used in the findings. Ethnicity data have not been attached to individuals for either the clients or staff participants; owing to the small numbers of participants and the array of ethnicities identified, individual participants could have been identified by this information. Identifying information within quotes has also been altered or removed to decrease the possibility of the participants being recognised. For example, specific days, times or dates have been changed if given, and location names removed and generic information given. For example, [city name] or [business name] has been used when a participant spoke about a specific city or a specific place of employment.

DATA COLLECTION

Data collection with the client and staff participants and data analysis occurred concurrently. Interviews were transcribed and analysed immediately and the analysis then informed the following interviews. To begin with, an overview of the client participants is provided.

Client Participants

Six client participants participated in a total of 16 interviews. Five of the participants completed all three interviews while one client participant became mentally unwell soon after completing the first interview, and based on the clinical team's recommendations, I did not continue with the other interviews with him. A limited amount of demographic data was collected.

Four of the six client participants made their first move to the community through the forensic NGO. One client participant was transitioning to accommodation which was regarded as a home for life, so this client was not expecting to move on from their accommodation and the final client participant was transitioning to accommodation overseen by Corrections. All clients were in different stages of their transition. Some were already living seven nights out of hospital while others were beginning their transition, staying between one and three nights a week out of hospital. During the data collection phase, each of the clients moved forward in their transitions. Two moved on to the wider community, living in their own flat with follow-up support coming to them weekly, and others moved to living at the supported accommodation seven nights a week. The length of time in hospital ranged from almost five to 13 years, though one client participant had come through the corrections service so had been in some type of secure environment for a total of 19 years. One client participant identified as Māori and the other five identified as either Pakeha, New Zealand European or European (Figure 2).

OVERVIEW OF THE CLIENT PARTICIPANTS

Pseudonym	Age	Gender	Time in Hospital	Time in Transition
Smelly	40-50yrs	Male	5-10yrs	3 months, though staying overnight in hospital during data collection
Harry	40-50yrs	Male	1-5yrs (15-20yrs within secure environments)	Staying overnight in hospital during data collection
Peter	30-40yrs	Male	1-5yrs	1yr
Jae	20-30yrs	Male	5-10yrs	1yr 6 months
Joe	40-50yrs	Male	10-15yrs	1yr 3 months
Sebastian	40-50yrs	Male	10-15yrs	1yr 3 months

One client participant identified as Maori and European

One client participant identified as Pakeha

One client participant identified as New Zealand European

Three client participants identified as European

Figure 2: Overview of the Client Participants

- Peter had been in hospital almost five years and was living six nights a week in the community at accommodation with 24 hours, seven days a week support. Peter engaged in all three interviews, often spontaneously asking clarifying question if he did not understand.
- Harry had been in a combination of hospital and prison for almost 20 years and had not yet left hospital. He actively engaged in all three interviews, often offering more depth to his answers without request. Harry took time to think about how he would respond.
- Sebastian had been in hospital over 10 years and held down regular part-time work in the community. He initially was spending more time in hospital but by the end of the data collection was spending six nights a week at the accommodation, the same as Peter.
- Joe had been in hospital over 10 years and was living six nights a week at the same accommodation as Peter and Sebastian. Initially apprehensive about the interviews, Joe relaxed as these progressed, smiling and joking at times.
- Smelly had been in hospital approximately seven years. Initially he was predominantly in hospital but by the end of data collection had moved into long-term accommodation with intensive support. This was different accommodation

from Peter, Sebastian and Joe. Smelly's interviews were stilted owing to his limited ability to engage in spontaneous conversation.

- Jae had been in hospital for over five years. He was living seven nights a week at the same accommodation as Peter, Sebastian and Joe. Jae participated in only one interview because he fell ill. He had difficulty remaining focused and would flit from one thing to another.

Further information about each of the participants, collated from their interviews, has been provided in an appendix (Appendix O). This allows an insight into each of the participants and into the way each client participant engaged in their interviews.

Owing to the chronic nature of mental illness, the clients had different levels of ability to engage in spontaneous verbal communication within their interviews, as will be seen in the next chapters. Often clients struggled to find thoughts in response to questions and so could then find it difficult to frame verbal responses to a question. Clients could also look to the interviewer for guidance on what to say so I needed to be careful to ensure I was not putting words in the client participant's mouths.

Levels of Verbal Communication

Forensic psychiatric clients will often not respond in detail when open questions are asked and this was seen by the client participants' of this research. A question like "tell me about your transition" is too broad for a client because of their struggle with forming spontaneous thought. Below is an excerpt from Smelly's transcript highlighting how broad questions can be challenging.

Interviewer: So what are you doing at [supported accommodation] during all the time now that you spend there?

Smelly: I'm writing a book.

Pause to wait for Smelly to elaborate

Interviewer: Tell me about your book?

Smelly: I've just about finished it

The transcript goes on to tease out what other things Smelly is doing; the information does not come out in one response but rather is teased out over the course of five to six questions.

Each of the client participants had varying levels of ability to engage verbally. Smelly and Jae were at the lower level of the spectrum while Harry and Peter were at the higher level, but none were at the level of the staff participants. It was important for me to include clients within the research because their voice is often missing from the literature (Völlm et al., 2017). This was challenging when verbal responses were poor; however, owing to my experience in working in this practice area, I was familiar with these challenges. The walking interview was an attempt to stimulate dialogue but that too was not as fruitful as I wanted.

The Interviews

Charmaz (2014) contends constructivist grounded theory encourages going back to the same participant many times because having many interviews with the same person allows the researcher to delve deeper. Because of this, the client participants were invited to three interviews, two being traditional qualitative face-to-face interviews and one a walking interview. Interview one focused on the client participant's own transition, interview two looked to explore the significance of place in relation to the client participant's transition and interview three was initially going to use photos taken during the walking interview to form the basis of the interview. However, owing to photos not being used it was used as an opportunity to check with the client participant the initial coding from their previous interviews and to discuss the developing codes. An interview guide (Appendix P), which incorporated a range of potential questions I could use for each interview, was developed to provide a starting point for each of the interviews. Deviations occurred as the client participants responded.

Interview One

The first interview occurred at either the client participant's home or the interview room at the hospital ward. Semi-structured, intensive interviews with open-ended questions were used. This allowed the client participant to tell their story of their transition into the community. It was also important for me to build rapport and a connection with the client participants before I invited them into a walking interview so this was the reason for starting with this type of interview. The first interview durations ranged from 35 to 60 minutes. All interviews were digitally voice recorded and transcribed in their entirety by me.

At the end of the interview the participant was invited to participate in a walking interview. The client participant was asked to think of a geographical location that was significant to them during their transition, one that they would like to walk around accompanied by me, and whereby the interview would focus on the area and their transition. Because of living a distance from the city where the research was being conducted, we agreed I would call them before my next visit to the city to confirm the location and timing of the walking interview. This meant the client participants did not have to try to identify where they would like to walk with little notice.

Interview Two – The Walking Interview

During the walking interview client participants were encouraged to talk about the significance of the location in relation to their transition; however, not all client participants did this. I had anticipated using the participatory walking interview, but found I used all three types I have explored in the methodology chapter, the go-along, participatory and bimbling walking interviews.

I accompanied Harry and Smelly on walks they routinely did around the hospital grounds, the route taken being part of their usual routine. I accompanied Joe on his regular route at the usual day and time, to the learning institution he attended. These three interviews were closer to the go-along interview. Sebastian's walking interview was closer to a bimbling interview. He had selected walking through the local botanical gardens; however, during the interview, I became aware this specific place did not have any real connection to him and his transition but rather it was a place he wanted to go that particular day. We spoke mostly about his transition experience rather than the geographical location we were in. Peter's walking interview fitted that of the participatory interview. During the walk, Peter spoke of why this area was important to him: he identified landmarks and spoke about their significance to him during his transition.

The walking interviews lasted between 35 and 60 minutes and were voice recorded and transcribed in their entirety by me. I found that many of the client participants spoke more spontaneously than I had experienced during the first interview. The client participants naturally spoke about the environment in which they were walking. However, the client participants' spontaneous conversation was not at the same level as the staff participants semi-structured, intensive interviews.

Several ethical dilemmas presented themselves during the walking interview (Kinney, 2018). Some of these I had anticipated and planned for, others arose during the walk and needed to be managed. Because of walking in public spaces, I was aware there was a likelihood the client participant would meet a person they knew. Prior to the walking interview I spoke with the client participant about what they would like to do if this occurred. Each client participant wanted to decide at the time as the response would depend on whom we met. Two client participants did meet people they knew. One did not want to engage with the person and was able to disengage by continuing to walk. I did not speak to the person whom the client participant knew. The second client participant introduced me to the person they knew and explained to them what they were doing.

I was mindful of walking in public spaces and that members of the public were milling close by. There was potential for members of the public to hear our conversation. I kept my voice at a level appropriate for the area where we were walking so not to highlight what we were doing. Client participants were reminded prior to commencing the walking interview of the potential for our conversation to be overheard so they could be mindful of what they were saying. On one occasion, I was with a client participant in an elevator with members of the public close by. Because of the close proximity, I chose not to keep talking to the client participant and waited until we had exited the elevator before continuing with the interview.

Safety of both the client participant and me was also considered. I had a clear set of processes in place which I followed prior to commencing a walking interview. These processes including checking in with staff prior to commencing a walking interview regarding the mental wellness of the client to ensure they were still able to attend. I also checked in with the client to make sure they still wanted to participate. I carried a phone with me in case of an emergency and I advised staff of my location and an estimate of how long the walking interview would take. I was unable to give exact details about the walking interview as it was directed by the client participant but a general location of where we were going to be was provided to staff. I also required the walking interviews to occur during the hours of daylight only and to not occur in isolated locations. Further details of the ethical considerations I made when using the walking interviews are overviewed in the Walking Interview Ethics chapter I have written (Appendix A).

Interview Three

The final interview occurred once the data from the first two interviews had been transcribed and the initial coding following constructivist grounded theory had been completed. This initial analysis was brought back to the client participant for checking. This final interview was an opportunity for me to check regarding the emerging categories and for the client participant to make changes to their data. I found this interview valuable as it allowed me to check my understandings with the client participants, to ensure I had accurately interpreted their voice. This interview also allowed me to check the emerging categories I believed were coming out of the data. The third interviews lasted between 25 and 60 minutes. All the interviews were digitally voice recorded and transcribed in their entirety by myself.

Staff Participants

The eight staff participants in the project were made up of both registered health professionals and support workers. Four staff participants worked at the forensic psychiatric service and four worked at the forensic NGO (Figure 3). The staff participants drew on their wider experience for the project rather than focusing only on their work with the specific client participants in the project. They provided an outsider perspective to this project. Interviews lasted between 47 and 72 minutes and were transcribed in their entirety by me. The majority of the interviews occurred in a private room at the staff's place of employment. One interview occurred at a local café close to the staff members place of employment.

OVERVIEW OF STAFF PARTICIPANTS

Pseudonym	Sam	Chris	Alex	Pat	Dale	Casey	Ash	Taylor
Age	50-60yrs	50-60yrs	50-60yrs	50-60yrs	20-30yrs	50-60yrs	50-60yrs	50-60yrs
Gender	Female	Female	Female	Female	Male	Male	Female	Female
Length of Employment	1-5yrs	10-15yrs	15-20yrs	5-10yrs	1-5yrs	5-10yrs	5-10yrs	1-5yrs
Length of experience with forensic psychiatric transitions	1-5yrs	5-10yrs	5-10yrs	1-5yrs	1-5yrs	1-5yrs	1-5yrs	1-5yrs

One participant identified as New Zealand Maori

One participant identified as New Zealand European/Kiwi

One participant identified as non-European

One participant identified as New Zealand/Pakeha

One participant identified as New Zealand/European

Three participants identified as European

Figure 3: Overview of Staff Participants

A limited amount of demographic data was collected, including ethnicity, length of employment, and length of time involved in supporting those in transition if this was different to length of employment. The staff participants' experience working with and supporting forensic psychiatric clients transition to the community ranged from 6 months to 18 years. The focus of the interview with staff participants was to explore their experience and knowledge of the transition process from hospital to the community. An interview guide (Appendix Q) was developed to incorporate a range of potential questions I could use, and was used as a starting point for each staff participant's interview. Deviations occurred as the participant responded to allow me to follow the staff participant's line of thinking. One of the staff participants requested the recorder be turned off while they spoke of their belief of what the service could improve on. They did not want that conversation recorded. Two other staff participants spoke in more detail about a number of their concerns once they had been advised the interview was finished and the recorder turned off.

DATA ANALYSIS

Though I have separated data collection and analysis for this thesis, in practice these two processes occur simultaneously. All types of grounded theory involve the constant

comparative method, where every part of the data, that is, the emerging codes, categories and properties, are constantly compared with the other parts of the data to explore variations and similarities (Hallberg, 2006). Three distinct areas are associated with grounded theory: coding, memo writing and theoretical sampling (Charmaz, 2001; Charmaz & Bryant, 2010).

CODING

Charmaz (2014) contends codes are constructed between the researcher and the participants within constructivist grounded theory. Researchers' perspectives, personal and professional experiences, and social location all affect how they code. Coding is the important link between the collecting of data and developing an emergent theory. Coding comprises an initial phase and then a focused, selective phase, which uses the most frequent and significant initial codes. Grounded theory coding need not be complex and should occur early in the research process.

The coding process relies on data; how and what is recorded will affect what a researcher has to code. Coding full interview transcriptions gives the researcher ideas and understandings that might otherwise be missed. Coding from full transcripts can bring a deeper understanding not gained from coding from notes alone. Coding from notes only will give the researcher a wider view; however, it increases the likelihood the researcher will go around the studied phenomenon rather than into it (Charmaz, 2014). For these reasons, I transcribed the interviews in their entirety and then coded the full transcript.

Initial Coding

Initial coding is completed using gerunds. A gerund is a verb that operates as a noun, commonly, -ing is added to the verb to give it properties of a noun, for example walk becomes a gerund when -ing is added (Makins, 1992). A strong sense of action and sequence occurs with gerunds because nouns turn into actions. Participants' own words are used because if they are ignored or a leap is made into participants' meanings and actions then the grounded theory will more likely reflect an outsider's rather than an insider's view. Outsiders will often use professional language, which is foreign to describing the phenomena (Charmaz, 2014; Thornberg & Charmaz, 2014). During my initial coding, I made sure I used gerunds to ensure my focus remained on actions.

Where possible I used the participant's own words within the initial codes so that the participant was central to the codes. Examples of my initial coding of a section of both a client participant's and a staff participant's interview is provided in the appendices (Appendix R). The use of gerunds is provided within this example.

Line-by-line coding is the usual method used by researchers for initial coding, and is the method I used. Coding every line seems arbitrary, especially since a sentence may take more than a line. However, it is encouraged because ideas may become visible that may not have occurred if the researcher was coding for themes alone. Surprises occur and by ensuring researchers stick with the line-by-line coding the likelihood that researchers superimpose their preconceived notions on the data is reduced (Charmaz, 2014; Thornberg & Charmaz, 2014). Though the process of line-by-line coding was laborious at times, I continued to follow this practice with all my transcripts. I formatted each transcript as my example in appendix AA is set out, ensuring a wide column to the left of the transcript. I then printed each transcript and worked with it in hard copy. I went through line by line writing the initial codes, using gerunds, as I saw them in the left-hand column. Initially, this process took time but as I became familiar with the technique my skill and confidence grew and I was able to move through the later interviews more quickly.

The practice of initial coding and constant comparative methods allows initial codes to be sorted and clustered. The process of sorting and clustering codes in turn allows the researcher to construct new codes and revise already-developed codes (Thornberg & Charmaz, 2014). Constant comparative methods are used to compare data with data to find similarities and differences; for example, interview statements and incidents within the same interview can be compared with statements and incidents in different interviews (Charmaz, 2014). During the process of line-by-line coding of transcripts, I also had the hard copies of previous initially coded interviews by my side. This allowed me to return to interviews already coded to compare what I had found with what I was currently coding. This method allowed me to compare previous interviews from the same participant, compare interviews among all the client or staff participants and to compare interviews between the client and staff participants. I also had a document open which allowed me to record my thoughts and questions which helped to inform subsequent interviews I had planned. This method ensured I was able to

identify gaps as they became apparent and to ensure I incorporated these into the next interviews I had planned.

In Vivo Codes

Codes using participants' words are referred to as in vivo codes. In vivo codes are symbolic of the speech and meaning the participants are using and can be seen to be innovative. Participants will articulate things in ways that both crystallise and condense meaning. Hearing these words allows the researcher to explore the meanings and understand the actions through coding and subsequent data collection. It is important to pursue telling terms. By understanding these terms, it provides the ability for the researcher to see similar understandings and meanings in others' words (Charmaz, 2014). During the process of initial coding I found myself using the words of my participants within the initial code several times; however, not all of them progressed into future codes. An example of an in vivo code I have used, *stretching the rubber band* (Appendix R), is provided in the staff participants transcript, I regarded it as an innovative term that captured the meaning and experience of a number of the participants. It now sits within the providing opportunities category in chapter seven.

Focused Coding

Focused coding is regarded as the second major phase of coding, and is more conceptual than the initial codes. Researchers do this by returning to the initial codes and selecting ones that are significant or combining numerous initial codes. These become focused codes for examining large amounts of data and they become tentative conceptual categories. Focus coding allows the researcher to direct their analysis early in the research process. It helps guide the researcher on what direction to take, without leading them down a path with no future. In focused coding the researcher engages with the most useful initial codes, which are tested against extensive data. Focused coding checks the preconceptions a researcher may have around a topic (Charmaz, 2014; Thornberg & Charmaz, 2014).

I commenced the process of focused coding when I was still completing initial coding with a number of my transcripts, as Charmaz (2014) contends the progression from initial coding to focused coding is seldom a linear process. I compared the breadth of initial codes I had constructed and looked for commonalities to see if I could combine any of them. I also highlighted initial codes which appeared significant to me owing to

the number of times they had arisen in multiple transcripts. An example of one of my focused codes, which has become a section in my finished work, is *Being Connected to People*, which sits within the *Inner Thinking: A Reason for Being* category. Being connected to friends, needing family, valuing family, having supportive people, needing friends, getting a good boss, and reconnecting to family are all examples of initial codes I linked together. The focused code *Being Connected to People* incorporates all these initial codes. I compared the focused code with new data as I completed further interviews. The focused codes became more abstract and conceptual and were used to develop the categories for the findings.

Memo writing is the second distinct area which is associated with grounded theory.

MEMO WRITING

According to Thornberg and Charmaz (2014), while researchers are collecting data, commencing their coding, and analysing data, questions will be raised which require answering in future interviews. Researchers will also develop ideas about their codes and the relationships they see forming among their codes. Researchers are expected to write down these questions and ideas as a way of remembering them. These analytic and conceptual notes are called Memos. Charmaz (2014) and Charmaz and Bryant (2010) advise memo writing is regarded fundamental to grounded theory and is the intermediary step between data collection and the writing of draft papers. During the process of writing memos, researchers are stepping back and analysing their ideas and codes that have developed, in every way that occurs to them in the moment they are writing the memos. There can be several methods used for memo writing; however, they should be spontaneous rather than mechanical. Researchers should use a method that is comfortable and natural for them and they should ensure they are becoming increasingly analytic within their memos. It is important for researchers to get their thoughts and ideas down as soon as possible so they do not lose those ideas.

I utilised my digital recorder for many of my initial memos and for my methodological journal. I found this tool to be important because I knew it was necessary for me to get my ideas, thoughts and evaluations out of my head soon after interviews were completed. When I returned to my home city I would re-listen to these recordings and then write down my thoughts and ideas. Sometimes I found my initial ideas and interpretations had changed and at other times they had not. Usually when I returned to

my home city I had completed several interviews so my thought processes now incorporated all the information rather than focusing on just one interview. I also carried a small notepad with me, even when I was not working specifically on my doctorate. Often, I would find myself involved in an activity or task which would connect me back to my doctoral research. I needed to write down these thoughts and ideas or I could have potentially lost them. It was these important connections and insights I developed over the course of my project that I incorporated into the development of the categories for my final thesis. I often used memos within this project as a way of remembering thoughts and ideas and exploring them as they came to me. During my memo writing process I found myself asking, “What’s happening here?” and “What sense do I make of it?”. Writing successive memos throughout the research allowed me to remain focused on the analysis and to increase the level of abstraction in the research (Birks & Mills, 2015; Charmaz, 2014; Thornberg & Charmaz, 2014). Memo writing is an important component of the third distinct area of grounded theory, theoretical sampling (Birks & Mills, 2015; Bryant, 2009).

THEORETICAL SAMPLING

Once tentative categories have been developed, the aim of the researcher is to explore them further to ensure nothing is left unknown, questionable or assumed. The researcher ensures the categories they believe are being constructed are robust and will stand firm. This is the time theoretical sampling is employed. Researchers gather more data that focuses specifically on the categories to elaborate and refine those that are used to develop the emerging theory (Charmaz, 2014; Charmaz & Bryant, 2010). Charmaz (2014) advises theoretical sampling generally occurs towards the end of the data collection stage, as researchers have moved from data to coding to memo writing. On paper this looks to be a seamless linear process; however, in reality it rarely is. Questions can arise at any point of the research, and categories may not present themselves to the researcher until considerable research has been completed.

I found after all the first interviews with the client participants, which had been concurrently occurring with several staff participants, tentative codes began to develop. I took these back to both groups of participants and found this process helped to refine and develop the codes further. It was during the last few third interviews with the client participants and the final two interviews with staff participants where I believed

the developing categories were becoming robust. The focus of these final interviews was on the categories and I used these interviews as a way of checking I had interpreted my data correctly.

Reference Panel

Once I had finished interviewing the participants I decided the categories would benefit from further checking to ensure the trustworthiness of the research. I brought together a panel of people I regarded as experts in transition from hospital to the community within forensic psychiatric services or similar services to talk through my categories and to see if there were any gaps or if I had made assumptions which were influential in the analysis. I was required to obtain approval from my university's ethics committee as this was a deviation from my original approval and I gained this in October 2016 (Appendix S). The panel was made up of individuals who were not associated with the research in anyway and had not been interviewed as part of the research. The panel consisted of the following:

- Two forensic psychiatric service staff members who were employed at a different service to where the research occurred. Both staff members were involved in developing transition plans for their clients and supporting those clients while in the community.
- One corrections ex-service user. This person had spent a period within the Aotearoa/New Zealand prison service and had transitioned back into the community.

I was not able to source a current or ex-service user of forensic psychiatric services who was outside of the research city for the panel. The panel was not privy to any of the original transcripts from the participants, but rather the panel members were presented with the constructed categories and I used selective examples from my interviews (without associating them to either staff or client participants) to support my interpretations. The panel was asked to evaluate whether the categories made sense to them and whether they could stand up by themselves. This interview was digitally recorded, which allowed me to return to the discussions later to check if I had missed anything in my notes or if I had misinterpreted what the panel was saying. The panel stated they supported the categories I presented, and they advised these made sense to them, agreeing with my interpretations as they reported seeing them with clients they

were working with or had experienced similar in their own transitions. These discussions also helped provide further depth to the categories.

Overall, I found constructivist grounded theory to be a useful methodology to guide this research project. Fundamentally, this methodology sits comfortably with how I see my world. The methodology not only allowed me, but, expected me to be part of the co-construction process of the interpretation of meaning of the participants experiences. This methodology allowed me the freedom and flexibility to incorporate both traditional semi-structured intensive interviews along with the walking interview. Crucially for me, as a novice researcher, it provided me with a systematic process which guided both the data collection and analysis steps of the research. I did find data analysis laborious and time consuming at times due to the requirement of line by line coding process (El Hussein, Hirst, Salyers, and Osuji 2014). As I became more confident and familiar with the process I was able to move more quickly through the data. I would recommend constructivist grounded theory to a novice researcher who was exploring a social process.

This chapter has provided the reader with an in-depth overview of the research process I undertook to complete the research project. The next two chapters present the findings, in the form of categories, which were constructed from the research.

7 TRANSITIONING THE APPARATUS

Transitioning from a hospital ward, to the community, for clients within a forensic psychiatric service was a process fraught with uncertainty. Clients transitioning attempted to navigate the apparatus which regulated both them and the transition process. The apparatus could be viewed as a cage, because the purpose was to contain and control how clients returned to the community. Foucault (1977) defined the apparatus as being the physical, institutional, attitudinal and knowledge structures in society which aimed to both increase and uphold power and control within social bodies. The apparatus the clients had to negotiate influenced the likelihood of each individual living in the community again. Overcoming the effects of the apparatus was not an easy process for clients, so staff assisted in counteracting its impact. This assistance enabled the door of the cage to open and for the clients to exit. This process supported clients in their attempts to regain their autonomy by building their confidence and skills. Yet the factors of success were not guaranteed. The focus of this chapter is on the institutional aspects of the transition, while the following chapter focuses on the participants' experience of transitioning.

This chapter is organised around four categories: *Negotiating the Apparatus*, *Providing Opportunities*, *Creating a Safe Haven* and *Factors for Success*. This chapter begins with *Negotiating the Apparatus*, a category depicting the structures that made up the apparatus which contained and controlled the clients' transition. *Providing Opportunities* and *Creating a Safe Haven* present the ways staff attempted to counteract the effects of the apparatus. The final category, *Factors for Success*, offers the key features for ensuring transition to the community was successful.

NEGOTIATING THE APPARATUS

The staff interviewed for this project spoke of their frustration at times with being hamstrung between the needs and wants of their clients, and the ability of the services within the community to provide, and at times, the desire to provide, what was needed to ensure the success of the transition for clients. The frustration by both staff and clients was evident during the interviews when some decisions by accommodation and activity providers were perceived to be made on the basis of prejudice, rather than

impartiality, and these flawed decisions then impacted on the whole client group. Negotiating the Apparatus encapsulated the tangible and intangible methods of control. Three sub-categories emerged from the data through my analysis: *Governed by Rules and Regulations*, *External Pressures* and *Managing Systems Capacity*.

Governed by Regulations and Rules

Forensic psychiatric services were governed by wide-reaching regulations and rules that influenced how clients within the forensic psychiatric service could be moved back into the community and how the clients could behave. Several of the regulations and rules were orchestrated predominantly by the legislation each client within the forensic psychiatric service came under and then by the policies and procedures outlined by external organisations.

Because of the nature of the forensic psychiatric service, the client participants were subject to compulsory treatment orders and, therefore, governed by the restrictions the legislation they were under dictated. Client participants in this study were predominantly under the CP (MIP) Act 2003 and were held as Special Patients. This meant they were governed by regulations which influenced the length and speed of the transition from the hospital ward to the community. These regulations were set out as a procedure that the forensic psychiatric service must follow to ensure approval was granted for the next reduction in security. A staff participant, Sam¹⁸, described the required series of steps for the transition process of Special Patient clients:

The cohort that are on Special Patient status, their length of transition and speed of transition is largely dictated by the Ministry of Health. So, we have a series of steps that we need to go through that include, escorted community leave, unescorted community leave, overnight leave up to 3 nights, overnight leaves up to 6 nights and then extended Ministerial Leave. Now that can take years. It depends on the client and it depends on the Ministry.

Sam (staff participant)

¹⁸ Gender neutral pseudonyms were chosen for staff participants and random gender allocations were made for each staff participant as a way of protecting their identity. The total of males and females equals the actual number in the research.

There were a number of regulatory groups and individuals that oversaw the different processes within the transition, such as the Special Patient Review Group (SPRG), Director of Area Mental Health Services (DAMHS) and the Minister of Health. Each of the groups or individuals required staff to submit a range of documentation and recommendations when requesting any alteration to leave. Clients were dependent on gaining approval from the groups or individuals before they could move on with their transition.

Staff participant, Sam also explained how the Residential Options Group (ROG) oversaw the placement of the clients into supported accommodation. The ROG was external to the forensic psychiatric service and obtaining approval from the group was necessary because the group controlled access to specific funding needed for supported accommodation.

The Residential Options Group give the approval and access the funding.

Sam (staff participant)

Joe, a client participant who was living six nights a week in the community but required to spend the seventh night on the open rehabilitation ward, explained he was not able to apply for ministerial long leave until the group responsible for his oversight (Special Patient Review Group or SPRG) approved the application. Joe was very familiar, as were all the client participants, with biding his time while waiting to hear what their outcomes would be.

They're going to apply shortly. Just waiting for the outcome of the SPRG group

Joe (interview three)

Parole was another area that some of the clients negotiated. For some, successfully obtaining parole was the first step in the transition, and then they were required to meet all the conditions stipulated by the parole board. For Harry, a client participant who was still living seven nights a week on the open rehabilitation ward and waiting to hear whether he would obtain parole, these conditions were going to be indefinite. Harry explained:

Well “life” in New Zealand is a minimum of ten years, which has changed now, but it’s an indefinite sentence or indeterminate and you’re on, once you get parole you’re on, Life Parole for the rest of your life, so you can be recalled back to prison, usually for something moderate to serious.

Harry (interview one)

The external regulations the forensic psychiatric service must follow influenced the structure and timing of any transition plans created for clients moving out of the hospital ward. Clients could be mentally well and ready to move out of the hospital ward; however, if the legislation and other external conditions they were under did not allow them to take those next steps, then they did not move.

Rules were another apparatus forensic psychiatric clients were required to negotiate during their transition. Rules provided security, structure and were often a source of frustration for the clients. Knowing the rules aided clients with the decisions and choices they made. How the client chose to respond to the multiple rules they were required to follow was likely to influence their transition in a number of ways, including the timing of increased liberty, the amount of time their move from the hospital ward to the community took, and how closely they were monitored by staff. Some of the client participants follow the rules without exception, while others have chosen not to follow the rules and the consequences for them was a loss of liberty. Yet other clients questioned why they are required to follow the rules. Rules included returning on time from any unescorted leave off of the hospital ward, taking all medications in the manner they had been prescribed, participating in all treatment indicated by their clinical team, and adhering to the hospital ward requirements, such as, being on time for meals.

Rules were also commonplace for clients who lived in supported accommodation. Rules within the supported accommodation, such as the forensic NGO, included notifying staff if the client had visitors at their flats, ensuring visitors had left by 10pm, ensuring the client was back in their flat by the curfew time, and ensuring the client engaged in the plan developed for them by their clinical team and supported accommodation staff.

Clients were also expected to follow rules when they lived in independent flats in the wider community too. These rules included meeting regularly with their case manager, engaging in the treatment plan developed for them by their clinical team, allowing the staff involved in their care to visit them at their flats, ensuring they took their required medication, and participating in tests to check they were in fact taking their regular medication.

Not following the rules often had a negative impact on the liberty of clients within the forensic psychiatric service. This was clearly explained by a number of the client participants within the study. Client participant Harry, who was still living full-time in the open rehabilitation ward, spoke about times when he did not follow rules during his time off the ward and the consequence was a reduction in his liberty for a time. Harry had been given unescorted leave in the grounds and was building up the time he was allowed off the ward with the hope of achieving unescorted leave in the community in the future. Harry had made a number of choices that broke the rules, such as smoking tobacco on the hospital grounds, and he had been caught. As a result, all his leave had been stopped and he started from the beginning again to prove he could follow the rules. This meant he returned to being required to have an escort with him in the hospital grounds when he went for a walk and he no longer could visit the wider community, even accompanied by staff. Harry was philosophical, accepting his role that resulted in the consequences. Harry acknowledged his decisions impacted on the reduction of his liberty:

Yep, as a consequence of that and there were a couple of other incidences like smoking on the grounds, rule breaches, that sort of thing, so... I sort of held myself back a wee bit.

Harry (interview one)

Harry was now back to unescorted leave on the hospital grounds and working towards gaining unescorted leave in the community. He advised he would follow all rules exactly as instructed to ensure he would be successful. He was acutely aware of the monitoring processes used to check he was following the rules. No matter how seemingly small and insignificant the rule might be it was still to be followed completely otherwise the consequences could be significant for clients transitioning.

For his walking interview client participant Smelly took me on a walk that followed the hospital ground boundaries, literally. The hospital grounds were the first location clients within forensic psychiatric services gained unescorted leave. It was important to take the walks that were allocated because if they were not used then support, by clinical staff, for increasing leave would not happen. As a result of this, Smelly walked the boundaries of the grounds as it took him close to his allocated 30 minutes. We walked parallel and close to a footpath but never used the footpath. Instead, we walked on the grass, which was wet from the recent rain. After enquiring why we were not walking on the path, Smelly advised that the footpath was outside of the hospital grounds and he was not allowed to be caught off the grounds without an escort. It was especially important to follow these rules because not only were staff from the forensic psychiatric service monitoring compliance but also members of the public kept watch and reported breaches to the media. Self-monitoring, to ensure rules were followed, was an important factor in proving to those in authority they could be trusted.

For many of the clients living within the supported accommodation there were rules about what activities they could participate in, the length of time they could participate in those activities, and the timing of when they participated. Programmes had been set up for each client while in the hospital ward and it was expected those programmes would be followed when the person was living in the supported accommodation. For some, having this routine was important, it provided consistency and familiarity; for others, it was another set of rules to follow and the perception was that there was limited choice in what they could do. Jae spoke of enjoying participating in X-Box. He would like to play as much as possible; however, he worked within several rules that dictated his use of this activity. Jae's rules stated he could not play before midday and he could not play after nine o'clock at night. Jae said:

I try to spend as much as I can. I can't play on it all the time cause they've got rules on the X-box, rules.

Jae (interview one)

Jae spoke of his disagreement with these rules; he preferred to play his X-Box rather than the activities staff had advised they expected him to engage in. Jae was compliant with following his rules, though, because he believed if he were not compliant then he would likely not be allowed to play his X-box in the future.

Moving to independent flats in the wider community signalled a reduction in rules to follow. However, there were still rules that sat outside those of the general population this group of clients were required to follow. Clients were expected to keep their appointments with clinicians, they were expected to take their prescribed medications and to consent to tests which checked the medication levels in their blood, they were expected to avoid illicit drugs and alcohol and they were expected to attend court dates with the judge when their compulsory treatment orders came up for review. Staff participant Taylor saw clients who had moved into the community making decisions that had the potential to compromise their continued success in the community. Many of the forensic psychiatric clients remained under compulsory treatment orders, which meant they were unable to make decisions about not attending an appointment with the judge regarding their legal status. Staff participant Taylor noted:

As people get in the community they do get that little bit of autonomy and they think “no, I’m not going to turn up, I don’t have to see the judge”, you know.

Taylor (staff participant)

Taylor advised forensic psychiatric service staff would drive and pick up clients and bring them to appointments, so they did not have negative consequences for not following the rules.

Rules provided security, structure and were often a source of frustration. Knowing the rules aided clients with decisions and choices. It was important for those transitioning to follow the rules to ensure negative consequences regarding their liberty did not happen.

External Pressures

Decisions regarding transition for individual clients moving into the community were often based on pressures that came from outside of the forensic psychiatric service and were not necessarily related to how the individual client had engaged with their treatment. The political environment, negative events occurring in the community, and policies held by external organisations all influenced the speed, timing, availability of options and structure of the process of moving from the hospital ward to the community for clients.

Staff participant Sam spoke of how transitions for the clients could take years because of external pressures, even if a client had demonstrated they were ready to move into the community. This was a factor they always had to be mindful of, Sam explained:

Currently we're moving into a post-liberal conservative period. And that comes in the wake of, a well-publicised flight out of the country and a conservative public view about Special Patients being at liberty in the community. So, we are sensitive to the public view, and our Special Patients are affected by that hugely. Ok, so we make recommendations but the public view and the Ministries' position at any given time affects the length of transition and speed.

Sam (staff participant)

What Sam was talking about here was a well-publicised escape from prison (Meng-Yee, 2016) and the impact this event has had on how clients within forensic psychiatric service are transitioned back to the community. Even though forensic psychiatric clients are overseen by the Ministry of Health and individuals within the prison service are overseen by the Ministry of Corrections, the impact on transitions was still significant.

Clients within forensic psychiatric services were of significant public interest because of the type of offences they had committed, for example, homicide, attempted homicide and aggravated assault. Generally, the clients had made the national news and a range of community organisations such as the Sensible Sentencing Trust took an interest in their specific cases. Furthermore, what was happening within the wider society, for example, a change of government or a person within Corrections service committing a serious offence while on parole, also impacted on what happened for individuals and their transition. Any negative event that occurred in the wider community, then negatively impacted on the transitions of the clients, even though the specific client transitioning had adhered to all restrictions and regulations that they were governed by. The public concern for the safety of the community influenced the political environment, and this in turn influenced how different Ministries conducted their oversight of forensic psychiatric clients.

The same staff participant Sam recalled two clients who were in their transition process and were of high public interest. These clients were regularly under the scrutiny of the

media and members of the public and as a result of external pressures had limits placed on them that both clients had to manage while in the community. Sam stated:

Well the two clients that we have that have committed murder and have been subjected to publicity in recent months and the scrutiny of the Sensible Sentencing Trust, have extensively, or so they're telling me, have accepted that as their cross to bear. Yep, but the impact for them is, that we need to advise them that they can't be seen in certain public areas at certain times, that they need to be mindful of their activities. We need to be mindful of where we take them, those are the impacts. So there are restrictions on the range of community exposures.

Sam (staff participant)

The clients were aware of these special circumstances outside their control and were resigned to following them because they wanted to progress in their move out of the hospital ward to the community.

Because of the perception of forensic psychiatric clients, held by both individuals and organisations in the community, there was often little choice for clients to find places to live permanently. Decisions by external organisations on whether to accept or decline a client were often made based on labels rather than an individual's history. Alex, a staff participant, spoke of the necessity of needing to be transparent about the forensic psychiatric service the clients were coming from to potential accommodation providers because it would influence any decision being made.

But you know, having to be very transparent about, where our patients are from is not easy. So, it's a stigma in itself, just the forensic label

Alex (staff participant)

Finding appropriate places for forensic psychiatric clients to move to from the hospital ward that had the level of support they needed provided many challenges for the staff.

Clients were also aware of the difficulties in finding them appropriate accommodation. The client participants spoke about the difficulties of having a place in the community to go to after the hospital ward, especially as they knew they needed support to develop necessary skills for living in the community, such as budgeting, home maintenance and

learning to interact with members of the public again. However, they were well aware that the label they held, not only as a forensic psychiatric client, but also as a Special Patient, impacted on whether they were accepted into a supported accommodation service and their personal achievements would not influence the decision. Having a forensic NGO that provided accommodation for a specific number of clients within the forensic psychiatric service, and specifically for those that were held as Special Patients, had provided hope for many of the clients.

Sebastian, a client participant who had increased his leave to the forensic NGO to six nights a week over the course of the data collection phase, spoke of his awareness that accommodation services in the community would limit access for those within forensic psychiatric services and of his appreciation of the organisation in which he currently lived. Sebastian said:

Yeah and the other thing too which is great is they're taking Special Patients. Not a lot of people want to know us, being Special Patients, a lot of people don't like even forensic patients, let alone Special Patients

Sebastian (interview three)

For Sebastian, knowing he had a place he could go to from the hospital ward had provided him with hope for his transition to the community.

Managing System Capacity

Managing system capacity referred to the range of systems staff within forensic psychiatric services are required to juggle during transition. At times, the decisions made by staff are not ones that would have been preferred, but because of factors out of their control, they had been required to make them.

The forensic NGO had a limited number of beds available to the forensic psychiatric service and these were usually at capacity. At times, immense pressure came on those few designated beds because staff within the forensic psychiatric service needed to transfer a client to the forensic NGO earlier than first anticipated. This pressure caused concern for the staff working within the forensic NGO because the required support and plan had not been arranged prior to the new client arriving. Decisions like these could then lead to potentially jeopardising a client's transition. Casey, a staff participant, spoke of this concern during his interview:

Try to find a way that..., you have to be very firm, you cannot be intimidated because a clinical team will say that person has to move, full on, now. If a proper plan, proper support is not in place I cannot jeopardise that persons transition because of that.

Casey (staff participant)

Casey believed finding a way to negotiate the pressure was important to ensuring the success of the transition for the client and at times that meant not accepting a person who did not have a support plan.

Ensuring clients continued to move through the forensic NGO was another system capacity which needed to be managed. Transitioning to the forensic NGO was not a final destination for the forensic psychiatric clients. The forensic NGO was viewed as a place where those forensic psychiatric clients who have spent considerable time within the hospital ward system could develop or redevelop necessary skills for living successfully in the community. Initially, many clients were both excited and anxious about returning to the community and the forensic NGO was a safe place for the clients to regain their confidence. After a time the focus moved to transitioning the clients into their own flat or a flat that was shared with others within the larger community. The vast majority of the clients viewed this as a positive step and were looking forward to moving out of accommodation which had 24 hours, seven days a week support. Where the next accommodation might be posed many difficulties. Staff participant Taylor discussed the challenges that occurred when the right accommodation was not located:

If we don't have anywhere to put them in the community they're not going to feel safe and the transition to the community's not going to work.

Taylor (staff participant)

Staff participant Alex also saw the accommodation in the community as being an issue. Alex explained her concern about where the clients moved to from the forensic NGO which was 24 hours, seven days a week supported accommodation:

Not all accommodation out in the community is as well resourced, just that one is, it would be interesting to know where to for them after this. So once they step down from the step down beds, how will they manage?

I would hope that things will be ok, but you don't have subsidised accommodation and you don't have subsidised food or power, those things are actually taken care of at the moment. So, when they move out from there then it might be a bit of a challenge.

Alex (staff participant)

Alex's comments were reiterated by other staff too, that all clients were expected to move on from the forensic NGO at some point in the future; however, the prospect of locating appropriate long-term accommodation for each person raised concerns for staff.

Conflict and unrest occurred at times for a number of clients who were ready to transition from the forensic NGO to independent living in the wider community. Clients often developed expectations about what their subsequent flat might be like based on visiting friends they had in the wider community and seeing what those individuals' flats were like. Unfortunately, assurances could not be given to individuals about the type or location of their new flat. For many clients, it was difficult to understand why they were unable to secure a flat similar to that of their friends. For staff, final decisions regarding a flat was often to do with what was available at the time and for many clients, their flat location came down to the luck of the draw.

Staff participant Pat spoke about a client who had been waiting to hear where their flat would be outside the forensic NGO and had their heart set on a flat similar to a friend because it had all the necessities they wanted. Staff, however, were unsure if any of those types of flats, in that geographical location would be available and as a result staff were concerned about how the client would respond if the news was not good.

There were also occasions where clients moved directly into the community from the hospital ward rather than going through the forensic NGO. The reasons for this could be numerous, such as there being no available beds at the forensic NGO, or that the client not deemed appropriate for the forensic NGO, because, for example, they had behavioural issues that could not be accommodated at the forensic NGO. The location of other appropriate accommodation can prove challenging for staff. Staff participant Taylor spoke of challenges she had experienced when clients moved directly into the community and the anxiety that was experienced by those clients and often the subsequent derailment of their transition. Taylor explained:

I've had one guy that just come straight, he'd been in prison most of his life and he came straight out into the community and it was, he was a struggle, it was a struggle for him, you know, he used to say, "I want to commit a crime and go back", because he was scared, he didn't know how to be in the community and the service he was under wasn't the [forensic NGO], he could have done well to go under [forensic NGO].

Taylor (staff participant)

What Taylor was saying here was that she saw the value of the forensic NGO for her clients, especially for those clients who had spent considerable time within controlled environments such as prison or forensic psychiatric services.

Funding and continued access to finances was another system capacity that required managing during the transition process for clients. Clients who occupied the limited designated forensic NGO beds were able to access specific funding that they could then use for a variety of purposes. Continued access and engagement in a range of activities that were both purposeful and meaningful to clients in the transition process was seen as important for the success of the client's transition. Many of those activities, such as gaining a driver's licence, using bus transport and going to the movies, have associated costs and the specific funding clients within the designated forensic NGO bed received was used to pay for these costs. When clients moved out of the designated forensic NGO bed they lost access to the specific funding.

A number of staff participants spoke of a forensic psychiatric client who had originally transitioned from the hospital ward to one of the forensic NGO beds. After a period he was transferred out of the designated forensic NGO bed and into a regular NGO bed; for the client, however, nothing appeared to have changed. He remained in his flat with all his possessions, and he remained under the forensic psychiatric service oversight. The only thing that was different was that, on paper, he was no longer occupying a designated forensic NGO bed. As a consequence, the specific forensic NGO funding he received ceased to exist. Many of the activities this client engaged in, such as going to the movies or even catching the bus to low cost or free activities, ceased because he was unable to afford them as he was now required to pay for these rather than using the allocated funding he previously had. Concern was raised by the staff because engagement in these activities helped maintain the client's wellness and he found it

difficult to understand why he was required to pay from his benefit rather than his previous funding. Dale, a staff participant, explained how this was confusing for the client.

He's in the same place, which is confusing for him, because I think he, he's not moving into the community and having his own place and seeing the difference from being in supported accommodation to somewhere completely different, to him, the funding and everything has been taken away, and these other guys are still getting that support and he quite often compares himself to them now.

Dale (staff participant)

Managing system capacity posed many challenges for the staff and clients during the transition process. Ensuring transition plans incorporated factors for success helped to address the range of apparatuses of transition.

The provision of opportunities for clients during their transition aided with their seeing a way through the apparatus of transition.

PROVIDING OPPORTUNITIES

After spending many years on the hospital wards and other secure environments returning to the community posed many challenges for clients. For many of them, having opportunities to try new things, opportunities to practise skills, or having opportunities to try doing things differently from the past, was difficult. Opportunities in a variety of areas included everyday activities such as cooking and cleaning, opportunities for social interaction, as well as gaining employment prospects and identifying future goals. These were seen as priorities for ensuring success of an individual's transition. The client participants' extensive hospital ward time meant they did not have the connections or the necessary skills or even the confidence to source their own opportunities. Having the opportunities prescribed built the clients' confidence in both the tasks they were completing and in their belief in themselves for the future. Staff provided opportunities for the clients to enable them to extend themselves to see that they could improve, to stretch the rubber band, so to speak. Finally, each opportunity had obstacles to overcome and overcoming them was a team effort. This required both the client and the staff to work together for the success of the

transition. Three sub-categories were constructed from of the data, *Opportunities Build Confidence*, *Stretching the Rubber Band* and *Overcoming Challenges*.

Opportunities Build Confidence

Having opportunities to engage in activities the clients saw as beneficial helped to build their confidence during their transition. Opportunities to practise skills that had been recently learnt, or were being regained, helped to ensure the success of the transition to the community. Seeing success and mastery promoted confidence to keep trying and extending themselves.

Staff participants believed a lack of confidence was one of the reasons some client participants would not participate in a number of activities. Being unsure of themselves and not knowing what the outcome might be was a reason not to try a new opportunity. Staff participant Taylor summed this up when she spoke about how a lack of confidence could impact on the transition to the community. The transition was about providing opportunities for clients to increase their confidence. Increased confidence increased the likelihood of connecting to the community again. Taylor explained:

I think a lot of it is they've lost confidence in themselves. They've lost, in fact, some of them might never have had a worker role but they've lost that confidence to be able to participate in the community and be part of the community and that whole transition thing is about getting them confident again. Getting them back to connecting to the community

Taylor (staff participant)

After significant time on a hospital ward, having confidence to complete everyday activities could be greatly reduced for clients. Everyday activities such as cooking, home maintenance and managing budgets are activities the public can take for granted. However, for a person who had been out of the community, these tasks were initially challenging, if not overwhelming. The forensic NGO was a safe place to relearn these activities.

Client participant Sebastian described how on the hospital ward he kept his room tidy and completed his personal washing. However, he had not mopped floors, cleaned a toilet or kept a whole flat tidy for a long time. When he started spending time at the forensic NGO he had opportunities to complete these everyday chores, with support

from the staff, and he had now moved on to completing these tasks independently. Sebastian noted:

I think it's just my confidence has built up over the years. Got more confident in myself with doing it. Yeah.

Sebastian (interview one)

Client participant Harry remained full-time at the open rehabilitation ward and had not yet begun overnight leave in the community; however, he spent time during the day off the hospital ward in the community engaged in a range of activities as part of his transition. Recently, he had completed voluntary work where he helped break down old computers into the component parts. Once all the computers had been broken down, the work ceased. The voluntary work had been arranged by the staff at the open rehabilitation ward. Harry advised he had been initially anxious about completing the work because of the concern about his performance and whether he could do the job. The job also required social interaction and Harry had been concerned about what the other people would be like. By continuing to attend the voluntary work and engaging in this opportunity, Harry's confidence in his own skills and ability grew. Harry said:

I suppose it was just familiarity of doing something repetitive. Yeah, just, gaining confidence at the time.

Harry (interview one)

All the participants spoke of the opportunities they had during their transition, most being activities that the public might take for granted, but for those transitioning, these opportunities could make significant changes in their world. Harry spoke of some of the opportunities he had that helped make his transition, to this point, a success. Harry stated:

I suppose learning about the computers and that sort of thing and going to the supermarket. Yeah just learning how to catch the bus and that sort of thing which has been quite valuable. Like I said, when I had that voluntary work that was good.

Harry (interview one)

For some, taking advantage of those opportunities caused anxiety and they chose not to continue with them until they were feeling sure they would be successful. Client participant Joe spoke of not being ready for paid employment at this point of his transition. Though Joe was living six nights a week at the forensic NGO and he was interested in it for the future he believed it was not useful for him currently. This was an opportunity he was going to leave till later. Joe commented:

I was, it was something that I was just like a motion I was going through. I wasn't really keen on finding work or anything. I've been in a job before and I didn't do very good at it.

Joe (interview three)

Joe's and Harry's experiences of work opportunities are examples of how each client's adaptation in their transition was not necessarily linked to where they were living in the community. Joe was living at the forensic NGO six nights a week and did not believe work was beneficial to him at this point, while Harry was still within the open rehabilitation ward and believed work was an activity which built his confidence and benefitted his recovery. Stretching the rubber band was an important aspect to keeping the transition moving forward for clients returning to the community. Stretching the rubber band was about the staff knowing the clients well enough to ensure the opportunities being provided to extend them was within their capabilities and that success was achieved.

Stretching the Rubber Band

Stretching the rubber band refers to the client extending themselves; however, they were firmly attached to the staff, as an anchor, so that they were not left dangling without support. Once clients had taken advantage of the opportunities and become confident in their ability, they were then encouraged to extend themselves past what they might feel comfortable with. The client was encouraged to extend themselves but not to the point where the rubber band would break. Trust and feelings of safety and security had been built between the client and their staff member and that allowed the client to feel confident to extend themselves. Staff participant Taylor spoke about a client whom she was encouraging to look for employment. She knew the client benefitted from being meaningfully occupied but lacked motivation at times to begin to

look for work. With the client, a goal of identifying three appropriate jobs the client could apply for was set and she followed up to check the client had achieved it. Taylor also spoke of a client who was living full-time in the community but was apprehensive about interacting socially with members of the public. Taylor would meet her client at different locations in the community so they would either go for a walk, visit a café or another location such as the supermarket as a way of allowing the client to practise social interaction with support. For Taylor, these were examples of stretching the rubber band and she explained it as being about encouraging the client to take those extra steps; however, trust should be developed first.

To get their trust, and to work at their pace you've got to be able to stretch that rubber band a bit, you know, you've got to be able to get them to feel comfortable taking that extra step.

Taylor (staff participant)

Staff participants Dale and Pat also recounted examples of where they had supported clients to stretch the rubber band while transitioning to the community. Both staff supported clients during the client's interactions with organisations such as WINZ. Initially the staff participants stated they would organise the appointments and lead the discussions with the staff from WINZ. Over time, as each client's confidence grew, Dale and Pat advised they would step back and encourage their clients to begin to take the lead in the interactions, and be ready to step in if the client indicated they were needing help. Each time the client saw themselves being successful encouraged them to take more responsibility next time. Stretching the rubber band supported the development of their client's confidence.

The client participants spoke about the challenges they experienced internally when staff would encourage them to extend themselves. Initial reluctance was common and at times some of the client participants described attempting to stop their progress, such as flatly refusing to complete activities or becoming angry or withdrawing. As the clients progressed through their transition and became more confident with their ability, they were more willing to extend themselves. Peter, a client participant who was living six nights a week at the forensic NGO, described how initially he was strongly resistant to suggestions and encouragement from the forensic psychiatric service staff. It was only through the passage of time and seeing the success he had made that Peter's

viewpoint changed. Peter could see how stretching the rubber band had helped him in his transition. Peter explained:

But now that I'm on this end of the journey I can see that they did what was best for me. Cause I feel/felt like I don't need that medication, don't need to have all their advice and I know what's right and they've actually given me a new lease on life. Whereas if I had have been through jail I would probably just be in a gang or doing crime, not prepared for the world, be angry, yeah. So the journey's helped me.

Peter (interview one)

Encouraging clients to continue with their progress was also important in stretching the rubber band. Clients could become overwhelmed with the struggle of pushing themselves and become focused on what they were feeling in the moment. Finding ways to ensure clients remained focused and motivated to continue to work on their transition was a priority for staff. Staff participant Chris explained what she believed she needed to do for a specific client she was supporting in their transition. Reminding the client about where they had come from was important for them. Chris explained:

I try to reiterate to him about staying focused, be positive, think about how far you've come as opposed to where you are now and how proud you should be of yourself and I think that, you know, helps with thinking to himself "oh yes I have done really well" and "yes I know this is my journey" and "yes you know I can see progress", again PROGRESS with capital letters.

Chris (staff participant)

What Chris was saying was that support and encouragement was an important component in helping the clients to continue to attempt to stretch the rubber band. Prompting clients to reflect on their journey was also part of stretching the rubber band.

Overcoming Challenges

Staff participants identified communication as being a significant hurdle for many of the clients transitioning. Social interaction and the ability to interpret social cues along with effective communication were all vital skills to ensure opportunities were taken for their

future. The chronic nature of the types of illnesses the clients lived with challenged their ability to verbalise information and interpret accurately non-verbal information from others, which then impacted on their ability to engage in activities. Client participant, Joe spoke of the difficulties he had experienced during the time he held employment. He advised he had difficulties using verbal communication with his boss and so he was not able to explain what he was thinking or feeling. As a result, his stress levels raised and he began to become mentally unwell. Joe advised that his unwellness resulted in him becoming paranoid and misinterpreting many of the non-verbal cues such as body language and tone of voice. He believed this resulted in him being laid off work because he was not able to communicate effectively.

My boss, I was a bit paranoid about my boss. I was a bit scared of him. Telling me what to do and stuff. Whenever he was there I was nervous. I think that is why he sort of got rid of me in the end. Cause I wasn't communicating with him too good.

Joe (interview one)

Staff participant Dale spoke generally about the clients he supported in transition. Many had great difficulty verbalising to staff how they were feeling, which was an important aspect to being in the community. Dale explained:

I think with a lot of these guys they're so used to being prompted about how they're feeling and they're not going to outright come out with the fact that they're feeling anxious, I don't even think they know how to put that into words sometimes.

Dale (staff participant)

The forensic psychiatric service had attempted to overcome the challenges of communication. The forensic psychiatric service had developed a range of therapy groups which addressed a number of the problems faced by the clients. Clients were encouraged to take part in these groups before engaging in social interaction within the community. Staff participant Sam explained that though opportunities for social engagement were regularly provided in everyday situations there was still difficulty experienced by the clients. Sam advised:

So we try and normalise those opportunities for social engagement however my experience tells me there are still, despite the exposure, there's still personal deficits. We've actually developed a group this year called Social Cognition Therapy and we're trying to teach our patients to better understand types of communication, non-verbal. Folk particularly with schizophrenia with negative symptoms have a great deal of difficulty interpreting social signals and affects and things like that.

Sam (staff participant)

Within the forensic NGO, clients were provided safe opportunities to practise the skills they were developing or relearning. Opportunities to cook, clean and engage in social interaction were numerous. Some of these tasks were complex, however. Concerns were raised by a number of the client participants living in the forensic NGO about how they would manage budgeting for rent, power and telephone when living in the wider community. Client participant Peter had not yet moved out of the forensic NGO; however, he was beginning to prepare to and was aware of these potential challenges for his future. Peter reported:

I know it's going to be hard out in the real world. Paying rent, power, food, telephone, internet connections, yeah all the bills. Here we're catered for, in every way.

Peter (interview one)

As a way of overcoming these challenges the clients who were at the forensic NGO and were getting ready to move into the wider community, such as Peter, were provided with the money to buy their own food, rather than vouchers to shop at specific supermarkets. This way they needed to look for the most economic supermarket or shops to buy their food. To support them, all clients were encouraged to complete budgeting groups to improve those skills.

Ensuring clients had people to support them when living in the community was also important. Support was fundamental for a client who was attempting to engage in opportunities for the first time or who were developing their confidence. Support encompassed a range of people who were available to the clients to help the client where needed, to provide encouragement to keep engaged with their treatment, and to

listen when the client wanted to talk. Successful outcomes were limited if the clients did not have people they trusted to support them because support aided in overcoming challenges. For clients within the forensic NGO, support was available 24 hours a day, seven days a week in the form of staff who were employed by the wider NGO. Staff participant Casey spoke of his concern when support for clients was not apparent when they had moved out of the forensic NGO. Once in the wider community, if support was not available then the potential for disruption was increased. Casey explained:

Some have nothing, no family, no friends, we are the family and that is the difficult part for us, to see how well that person could do or not when that support is gone.

Casey (staff participant)

One of the most significant complexities clients had to overcome was the stigma and subsequent discrimination when transitioning in to the community. Client participant Harry spoke of the challenges he believed he would face as he moved into the community. He was aware that the stigma he would experience would impact on his transition and he believed he needed to manage that himself. Harry was still a prisoner and was waiting to hear if he was successful in obtaining parole. He was serving his sentence in an area away from where he was born and had been brought up. He was aware he was not going to be allowed to return to his birth location and so would need to transition into the area he was currently located. His parents were his only source of support outside of the professionals who were involved in his treatment and care. Because his parents were aging, Harry knew the challenges he would experience when they were no longer there. Harry explained:

Well there's always going to be a stigma attached to me. You know, being a life sentence prisoner, but I just have to learn to cope with that, I suppose my parents are not going to be around for ever and when they pass on that's going to be probably quite a hard time for me.

Harry (interview one)

Stigma and discrimination were very real consequences of being within a forensic psychiatric service and challenges to overcome. The forensic psychiatric service worked to normalise the opportunities each client would experience in an attempt to

overcome these consequences; however, they could not be completely negated. Support, in the form of people, was one of the main ways this barrier was overcome. Creating a safe haven for clients transitioning also helped to navigate the apparatus of transition.

CREATING A SAFE HAVEN

The ability to feel safe in the community was an important aspect to the success of the transition from the hospital ward to the community for those within the forensic psychiatric service. Safety and security encompassed more than ensuring each person had a reliable and appropriate place to live. A safe haven also included emotional security, social inclusion and feelings of trust in those who had responsibility for the transition process and being trusted by those same people.

Both the client and staff participants spoke during their interviews about the need to create safe spaces when moving on from the hospital ward, and both groups of participants discussed the range of factors that should be considered to ensure a safe haven was created. This included the place the person would be living for their time in the community, a place they could call their own, and a space they could set up as their own. Knowing the people who had the responsibility of overseeing the transition process would protect them was an important factor for those transitioning. Finally, helping to facilitate a sense of belonging to the community helped to create a safe haven. Three sub-categories were constructed from my analysis: *Safe Spaces*, *Providing Protection* and *Needing to Belong*.

Safe Spaces

Having safe spaces were important to the clients in this study who were adapting to living in the community again. These were spaces where clients could spend time contemplating their future, take time out from their busy programmes, or just to relax and regenerate their energy. For most of the client participants, their main safe space were their flats within the forensic NGO, either alone or sharing with others. For some of the client participants, like Jae, there were specific spaces within their flats where they liked to spend time thinking. Jae lived alone in his flat at the forensic NGO and had a specific space in his lounge area where he would sit for 30 minutes each day. As Jae stated in his interview, his flat was a place he felt safe.

I feel good, I feel safe by myself and stuff.

Jae (interview one)

Each of the client participants were also able to identify spaces in the wider community area where they felt safe to spend time. When in these places, they often spent time thinking about their future, or trying to process thoughts and feelings that were occurring for them at the time. Client participant Sebastian spoke of spending hours walking through the botanical gardens. He enjoyed the fact there were many spaces within the botanical gardens where he could go and relax. These were spaces where he could mingle and be part of the crowd or be invisible to others while he was thinking through any issues he had at the time, such as how he would manage when he visited WINZ or how he would ensure his flat at the forensic NGO would remain clean and tidy. Client participant Harry talked about a seat he used on a regular walk he completed each day within the hospital grounds. The seat was within the boundaries of the hospital grounds but could not be seen from his hospital ward so was a private place for him to spend time. He would take time sitting when he needed to, and it was a space where he felt safe to relax and contemplate his future including what he wanted to do when he was no longer within the hospital grounds. The seat was also a space he felt safe to practise relaxation techniques, such as mindfulness and breathing exercises he used as a way of managing his anxiety.

Finding spaces and facilitating connections to them took time. Not all clients were necessarily successful and the staff participants spoke of both the successes and challenges they faced over the time they supported clients transitioning to the community. Staff participant Chris spoke of the safety that clients felt within the hospital ward and how the team helped to nurture the connections to the new spaces clients would use when they left the hospital wards. These spaces included the flats the clients would live in, be they at the forensic NGO or independent flats, and the suburb the clients would spend time in outside their flats. The ward often felt like home, and though the clients were keen and willing to move on, feelings of safety were often associated with the hospital ward, and this was why a number of the clients liked returning to the hospital ward to visit, and sometimes, why a client sabotaged their transition because they wanted to return to a place that felt like home. Ways clients sabotaged their transition included not taking prescribed medication, consuming illicit

drugs or alcohol, or returning to past criminal behaviours as a way of coping with their stress and anxiety of being out of the hospital ward. Chris explained why a client may sabotage their move to the community:

So they don't have the balance like they have back at the ward where they feel really safe, cause like I said it's like home for them.

Chris (staff participant)

The wider community, which includes all the areas outside the suburb the client lived in or where the hospital ward was located, was a large place that clients needed to negotiate and manoeuvre in and around. Thus, the forensic psychiatric service took a graded approach to introducing clients to the community. The staff were aware of how overwhelming it could be for clients when they first started spending time outside the hospital ward again. Staff participant Sam spoke about the changes in confidence he had seen in a client who was in the process of transitioning to the community. Sam explained:

We've got one fellow here [clients name], he's moved over 18 months from being afraid to go walking in the grounds [hospital] to now he goes and spends a day down at the mall, he buses to places, he goes to [NGO organisation] one day a week all on his own and he's achieved that in 18 months

Sam (staff participant)

Providing safe spaces helped nurture the feelings of security and trust in the community. Having places where clients could take time out in, spend time thinking and contemplating their futures, and were safe for clients to relax their guard was important for the success of their transition and these took time and were not always linear.

Providing Protection

As part of creating a safe haven for clients making the move to the community another important factor was the need for staff to provide protection when necessary, as this helped clients develop trust in the staff and feelings of safety when the clients were with staff. Protection could come in many forms, for example, advocating for their

clients with other services and organisations to ensure the clients' needs were incorporated into decisions being made. Staff, at times, were required to step in to help clients with tasks and activities because the client struggled with social anxiety, or was confused with what was being asked of them, or did not have the vocabulary to adequately explain to another person what their needs were; for example, staff were often asked to help when clients were attending WINZ appointments or meeting with bank staff. Staff also were the people with whom the clients discussed any issues that arose, such as concerns about their lack of employment, where to buy their groceries or how to manage other clients who were annoying them, because the staff had built trust and rapport with the clients, and the clients felt safe with them, and knew they would be protected in their time of need.

When clients first begin their transition to the community completing everyday activities such as grocery shopping, talking to bank tellers or explaining their needs to staff at organisations that oversaw their benefits could be intimidating. Knowing that the way they interacted with these members of the public could have a significant impact on the service they received was, at times, overwhelming for some clients. Client participant Peter spoke of past historical experiences when attending WINZ appointments by himself and compared them to visits when his peer support worker was present. There were strikingly different outcomes for him. Having a peer support worker advocating for him meant he received his entitlements with little difficulty. Peter said:

If I need to go to an appointment and I need support they'll come. Like, when I go to [agency] to get my job start grant I take my peer support worker because I notice when I go to [agency] by myself they dick me around and I know it's their job to not let you know what you're entitled to cause the government wants to save money, they're not here to hand out money to everybody, they'll, lead you astray and say "oh go away", you know, instead of sitting there saying "oh look you're allocated \$1200 each year or this, this and this and you can get a clothing grant for this". They won't sit there and tell you everything you're entitled too. So, I find

taking peer support worker with me, they don't do that. They're more than happy to engage with me and give what's necessary.

Peter (interview three)

Staff participants spoke of times where they would step in and help clients communicate with members of the public. They encouraged the clients to lead the process but tried not to step in too quickly because it was important that the client themselves had opportunities to build their confidence. Staff participant Dale explained the range of tasks he would help clients with, included taking clients to complete grocery shopping or attending appointments with clients. For Dale, the key was letting the client drive the process.

We are accompanying them in the community to places like, grocery shopping, community centres where they liaise with other people. Quite often we'll take them to see, family, friends, if they're struggling, if they feel like they need a support person with them, we'll accompany them. Places like, [the local mall], bank if they're not capable of going up to the teller and just saying I need this, just getting them sort of settled. Driving lessons if they feel they need support, it's a lot to do with how they feel, they're capable of doing a task and whether they need support or not

Dale (staff participant)

What Dale was saying was that clients drove the decisions on whether they needed or wanted support completing these everyday tasks. For staff to be able to provide the protection, rapport and trust first needed to be established. Knowing the staff were available to help and wanted to do what was necessary to make sure the transition was successful ensured clients came to staff for help when they needed it.

Building rapport and trust took time and it was an area both staff and client participants spoke about. Being available when clients needed them was highlighted by the staff participants as necessary for rapport building and gaining clients' trust. Staff participant Casey discussed the range of areas staff were available to help clients, including general household maintenance, problem-solving difficulties clients had with their computers, working out the quickest route through the city to drive to a client's parent home,

showing how to use the bus service or having a supportive ear when clients needed to talk through their anxieties about being in the community. He described the feelings of security and safety clients experienced, which helped create the safe haven. Casey explained:

They feel secure because they know they have support, they have someone to talk with if they need. They can come and have a chat with staff.

Casey (staff participant)

At times, staff were required to intervene and advocate for their clients with service providers when the client did not have the ability to use their voice. They did not have the vocabulary to adequately explain what they wanted or the confidence to articulate what they needed. For this reason, staff were called upon to step in and advocate for their clients. For example, staff participant Sam had a client who had been offered a place in the community by the Residential Options Group (ROG) and she was aware the placement would not suit her client. It was in an organisation that had religious values and they were not ones the client held. Sam advocated for her client to influence change:

It's not what he wants so my role is to go back to the ROG and just sort of run interference on that. Somethings happened and it, my view is, if I don't do that it's going to fall down. I believe it will, [clients name] doesn't want that. He wants a flat with support coming in so I need to go back and influence a change there.

Sam (staff participant)

Advocating for clients, with organisations that could be intimidating for a person who did not have the confidence or vocabulary to advocate for themselves was an important way for staff to provide protection for their clients.

Needing to Belong

Belonging did not necessarily come naturally and was something the staff actively facilitated. Knowing they belonged was an important factor for the clients to feel safe in the community, and so helped establish the community as a safe haven. When

clients found it difficult to belong or if they had a sense of belonging to the place they were moving from but had not yet established a connection to the new place, then issues could arise for those clients. A sense of belonging was articulated by both client and staff participants as important in establishing a sense of safety.

Client participant Peter also spoke of moving out of the hospital ward and the process that it had taken. He had been connected to the ward and the safety it provided. He was happy he had not just been “dumped” at the forensic NGO and left to connect to it by himself. The graded process he went through to living in the forensic NGO helped connect him to it and see it as a safe haven. Peter explained:

It was a gradual thing. Its not like all of a sudden you're chucked to here and let go. You're still going back [to the hospital ward] and you might be here one night a week and you could do that for several weeks and then here [forensic NGO] 2/3 nights and they're monitoring you and they can see whether it's good for you or not, whether you're going to fail. It would be too much just to be dumped off here 6/7 nights a week, all at once.

Peter (interview three)

Peter described a sense of belonging as being very important to him and his sense of belonging was multifaceted. He described the importance of belonging to the place he was currently living, the forensic NGO, as well as to his family and friends.

Staff participants also articulated the importance of belonging. They described some of the techniques they used to help build the connections to place with their clients. Spending time in the wider community with clients was indicated as important by many of the staff participants. Having opportunities to engage with clients in areas the client would spend time in the future was important for the clients to see that it was also a safe place. Walking around a local park, going for coffee at a nearby café or accompanying clients on visits to organisations all helped facilitate a sense of belonging.

To help facilitate a sense of belonging, staff participant Taylor spoke of how important it was to know the client well. Knowing what they wanted to do, how they reacted and where to find what was needed in the community were all necessary to help with the facilitation of belonging. Taylor explained:

I don't think you can undermine how important it is and it's achieved by knowing your client, knowing what pointers, what areas to sort of direct them in, knowing what's out there yourself, knowing what's not out there anymore. You know what I mean? You've got to be aware of the community yourself and you know, to be inclusive in it and to try to include someone else in it.

Taylor (staff participant)

The clients experiencing a sense of belonging was personal, it was about the feelings they experienced when with others or in a specific place. Client participant Joe described his sense of belonging with regards to feelings he experienced with other people. A sense of belonging to place came when he was connected to the people within that place. Having a relationship with others that was based on trust and included transparent communication represented belonging. Joe said:

Trust, communication, personal relationships, you know, yeah.

Joe (interview three)

When these components were explored further with Joe he explained a sense of belonging for him was related to the personal relationships he had with people within the different communities he wanted to belong. For example, the forensic NGO was where Joe lived and his relationship with the staff there was important for his sense of belonging. Trust and communication had to be reciprocated. He spoke of the trust staff had of him that he would do as he said, take his medication, and attend appointments on time. He trusted the staff to support him when he needed and to communicate honestly with him.

For other clients, a sense of belonging related to what they were doing. When the client believed they belonged then the activities they were engaged in represented their sense of belonging. Client participant Sebastian spoke of the importance of this during one of his interviews. By being actively engaged in a range of activities that were based in the community and contributed to the community gave Sebastian a sense of belonging. Sebastian explained:

Oh, just doing what I'm doing. Keeping involved with different groups, different things, keeping myself busy, keeping myself occupied, keeping my activities of daily living (ADLs) up, stuff like that.

Sebastian (interview three)

Sebastian was engaged in a community group which supported individuals financially to complete activities they were interested in. By attending meetings regularly and actively taking part in the meetings, he believed he belonged to the group. He also was an active member within his church and took responsibility for his flat maintenance at the forensic NGO, which also facilitated his sense of belonging to there.

For some moving to the community, feelings of safety and belonging were very much connected to the hospital ward and establishing those feelings to another place that was unfamiliar took time. Staff participant Chris spoke of the range of clients she had seen move to the community. When visiting several clients in their new homes, their new sense of belonging was apparent. Those clients were proud of their new home and wanted to bring staff in to visit. Others found connecting to their new home difficult, their safety was more tied to the hospital ward and they continued to view the hospital ward as their home. Chris explained:

Some have done really well, invited you in, made you feel comfortable. They are really proud of their new home because that is what it is. Then there's others that may be still thinking, "it's a huge a step for me" and, "am I going to trip up", "everybody's going to be watching me". So they don't have the balance like they have back at the ward where they feel really safe, cause like I said it's like home for them.

Chris (staff participant)

What Chris was saying was establishing a sense of belonging to the new accommodation was an important component for clients to successfully transition to the community.

Clients' connections to the community were linked to how the people in the community viewed them. Coping with stigma and the subsequent discrimination was difficult for clients to overcome. Feelings that forensic psychiatric clients were second-grade citizens were experienced, and as a result, clients were marginalised in society.

Overcoming these views and at the same time attempting to ensure clients felt safe in the community was a priority for staff. Staff also felt frustration with the community and could see the negative impact on their clients that stigma and discrimination had. Staff participant Taylor spoke about one client who struggled to connect to the community because he viewed himself as being less than those who were part of the general population. Taylor explained:

When you've got a young man who's healthy and fit and it's his confidence and his inability to think that he could be part of that world is poor and that's sad, cause, not sad, sad, but you know, there's work to be done with him because there's a possibility he could with time make steps and achieve something, we hope.

Taylor (staff participant)

Taylor went on to explain she spent her time, when working with this client, attempting to find different ways that supported developing a sense of belonging for the client. She looked at what they wanted to do as a job and worked with the client on options. She also looked at the different resources in the community that were close to where the person lived and attempted to link them to the activities associated with them, for example, going to the gym.

For some clients, moving on from the hospital ward and the forensic NGO to the wider community was intimidating. Without the 24 hours, seven days a week support some clients became isolated in their accommodation. Their transition was still deemed a success because they were not offending, and were taking their medication; however, some of the staff participants questioned whether the clients' quality of life should be considered when looking at success. Staff participant Ash spoke of a client she was aware of whose self-care had deteriorated since moving to the wider community but was still regarded as doing well because he was taking medication and were not offending. Ash explained:

He's been living in a flat, apparently his flat's filthy but he's not offending, you know, he's doing alright but you know.

Ash (staff participant)

Staff participant Alex spoke of similar instances describing how some transitions end up failing because follow-up of the client was not undertaken. Staff need to help facilitate a sense of belonging to the community because this in turn increased the likelihood of success in community living.

It's all very well for us to find them a place, get them set up and say "look this is how much money you've got" and then leave them and that's it and that doesn't take long before they fall over and I've seen that so often, yeah.

Alex (staff participant)

Alex and Ash were reiterating their belief that clients who are living in independent flats in the wider community required support and follow-up. Clients who had experienced a sense of belonging in the hospital ward or the forensic NGO would also need help to develop a sense of belonging to their new accommodation. If this did not occur then it was likely successful community living would not be maintained.

A sense of belonging to the community required facilitation and was a role staff took when supporting transitions to the community. The sense of belonging was personal to each client. When a lack of belonging was experienced by those transitioning then the transition could be compromised, or the quality of life a person experiences could be significantly reduced. Creating a safe haven, which incorporated both the physical surroundings and emotional security of the individual, helped to ensure a successful transition.

If strategies to counteract the effects of the apparatus, such as providing opportunities and creating a safe haven were to occur, then, the forensic psychiatric service was required to develop transition plans which incorporated factors for success.

FACTORS FOR SUCCESS

All client transitions began with a plan, and the development of the plan was to move the client back into the community. This usually began from the moment the client came into the hospital wards. Whenever possible, staff involved the client as much as practicable in the decision-making; however, not all decisions could be made by either the client or staff. Keeping the focus of the transition on the future and the possibilities

that it could hold for the client helped to install hope. This transition required working in collaboration with others, these including the person transitioning, outside organisations and the forensic psychiatric service itself, where each client was treated as an individual. Two subcategories emerged from the data through my analysis: *Everyone's an Individual* and *Working in Collaboration*.

Everyone's an Individual

For transitions to be successful they needed to be individualised and based on the needs of the person who was transitioning. The length of time each transition took to completely move a client from the hospital ward to the community (figure 1), and for that person to feel settled within the wider community, varied for each person. Staff participant Chris talked about a client whose transition had taken a lot longer than was first anticipated. Not returning to the secure hospital ward was regarded as progress and seen as just as important as increasing time in the community. Chris explained:

At the moment, he's doing extremely well, he's getting out on four nights' leave, he's also working in the community, so even though it's taken him this amount of time [years], he's still getting there, so its progress. So he's not going backwards as in, he hasn't moved back over to [secure ward] permanently or [long-term secure ward] permanently, he's just made slow progress from [open rehabilitation ward], but he is definitely getting there. So, it's almost like baby steps.

Chris (staff participant)

Many factors could influence the time the move took, and how the individual engaged in the process was an important factor. Chris, a staff member, spoke about how the length of a transition could come down to the person themselves, if they engaged with the plan, followed the rules outlined by the clinical team, and progress had been determined by staff, then moving out of the hospital ward could occur. Chris explained:

Well because the transition can be, a short a transition, or, it can be long transition, so again, it comes right down to the client, you know, how far

they've progressed while they're here.

Chris (staff participant)

Where a client progressed to, from the hospital ward was also individualised. Many of the clients moving into the community initially began by starting at supported accommodation which had 24 hours, seven days a week staffing, such as the forensic NGO, before moving into independent flats, either alone or shared with others. Other clients moved directly to living in independent flats, with support staff visiting daily, weekly or two to three times during a week. Staff participants advised decisions about whether a person needed the higher level of support was often based on how long the person had been on the hospital ward, what community living skills they needed to develop or redevelop, and what legislation they were under.

Staff participant Taylor described how important it was to consider the length of time a person had been within the hospital ward, and particularly, how long they had been away from completing everyday activities such as budgeting, cooking and managing a flat when deciding where they should be discharged to from the hospital ward. Taylor explained:

So they have to be able to budget, they have to understand about money and be able to pay their rent and pay their bills because if not they get evicted, ok, so that's the first thing I look at, can they do that?

Taylor (staff participant)

Taylor was saying decisions about where a person may be discharged to from the hospital ward was based on the needs of the individual wherever possible.

The inclusion of individualised factors for success was not always possible. There were factors that overrode the individual clients' needs and these had the potential to negatively impact on the success of the transition. For example, legislation could dictate the speed transition occurred; if a person did not have the appropriate approvals that allowed for permanent residence in the community, then they could not stay seven nights a week out of the hospital ward, even if their recovery benefitted from it. A number of the client participants in this research fitted into this category. Sebastian, Joe, and Peter were required to return to the hospital ward one night every week. External pressures such as bed pressure could mean a person moved faster than they

needed to, and this was seen with client participant Jae in this study too. The bed he held at the forensic NGO was needed by another client moving out of the hospital ward so he was moved and the impact on his transition was negative. This is explored further in the next category. System capacity also influenced whether a transition was focused on individual needs. Staff participants Taylor, Pat and Chris all spoke about how keeping a client longer on the hospital ward or the supported accommodation or taking an independent flat that did not quite meet the individual's needs was a difficult decision to make, especially if the person saw being in the community outweighing the negatives of the living space.

Success of the transition was also dependent on the clients having choices within the plan and truly believing they could influence the decisions that their clinical team were making. Each of the client participants in this study spoke of the importance of being able to be involved in the decision-making. Each of the client participants acknowledged that not all decisions were able to be made by them; however, if they were to be engaged in the transition process then their choices needed to be incorporated into the plan. When asked about being involved in making decisions about what he engaged in doing while in the community client participant, Joe believed his decision making was important for his enjoyment. Joe stated:

Very important because you do things that, you try to do things that you want to do and not what other people want you to do and if you're doing something that someone else wants you to do but you don't want to do it, you're not going to enjoy it

Joe (interview three)

Sometimes, decisions made by clients were not ones that staff understood or necessarily supported. This then caused concern for staff because of the unsettling nature of the choices being made. Staff participant Taylor spoke of two of the clients she supported in the community. Even though they had made decisions which concerned her it was important to support them because the clients had the right to make decisions for themselves. Taylor said:

I have two clients, one was doing voluntary work and one was working and they both decided they weren't going to do that and it was their

right, and you know, I had concerns because I don't know how they are going to spend their time, you know, but that was their right, they took that autonomy and decided that was what they were going to do, and they can, they have a right too

Taylor (staff participant)

Taylor was still supporting these clients in the community. The long-term impact of their choices was not yet known; however, Taylor continued to work alongside them to see if they could identify other activities they were prepared to complete.

The development of a transition plan was an important first step in moving clients out of the hospital ward and towards the community. Incorporating the individual needs of the clients, when possible, and involving clients in the decisions enabled them to connect to the plan and see the purpose of what they were doing. But this also involved many people and organisations working collaboratively with the client themselves as well as each other. Ensuring clear communication as well as incorporating the needs of the person and organisations helped ensure the success of the transition.

Working in Collaboration

Working in collaboration was not one service telling another service what to do or the forensic psychiatric service telling the client what their transition would be like. Working in collaboration required all parties to work together to ensure a successful outcome for the clients. For example, the forensic psychiatric service was required to make sure of clear and consistent communication with the organisations providing accommodation or support to their clients.

Working in collaboration began before the client set foot in their new accommodation. Ash, a staff participant, spoke of the process of when a new client was getting ready to come to the forensic NGO from the hospital ward. For example, the client would be introduced to several staff, and their faces would be familiar when they arrived at the forensic NGO. This aided the collaboration between the forensic NGO and the client themselves. Ash said:

We'll go in there and get introduced. If you've got someone new coming along, they're really supportive in introducing us to the clients or to people we support and there's no real break. It's not like, they're sitting

in a ward at [hospital] and all of a sudden a funding person says you're going to [NGO organisation] and they just come. There's a whole supportive process behind it, they don't just get dumped here with a box and a few blankets, which I've seen happen before.

Ash (staff participant)

Ensuring the transition from the hospital ward to the community was successful was the priority for all those involved; however, several challenges were highlighted by both the staff and client participants which influenced the success of the transition.

A threat to collaboration needed for successful transitions was raised by staff participants about plans that had been instituted by one team but not being followed through by the receiving team. Staff participant Alex gave an example of her concern in seeing the work the team she was involved with falling over and the negative impact that happened for the person transitioning. Alex explained:

What I have seen quite often, is that you can put a very comprehensive robust plan for the patient and it looks really achievable and it's a doer and you can see long term, from where we sit, that it will carry on out there in the community. It will carry on if that case manager follows through with the plan and the recommendations. If the case manager in the community is prepared to follow through with it. It doesn't happen. I've seen it fall over many times, we [team] are horrified that the patient hasn't been followed through with and it's very, very frustrating.

Alex (staff participant)

Another threat to collaboration was raised by staff participant Dale about plans that were put in place by one team that the receiving team did not see as sustainable or helpful for the client. Dale gave an example of where a client was to view the staff at the forensic NGO as 'family' as a way of trying to get the client to connect to the forensic NGO. Dale's concern was regarding the forensic NGO as being a transient part of the clients move to the wider community and the client would be expected to move on in the future and Dales concern was how might this then impact on their integration to the community. Dale explained:

One of them is that [NGO service] is my home and we are your family, I think that's another rule, I kind of disagree with that because he's eventually going to be moved on, he's going to have another service that he's going to then look at them as his family.

Dale (staff participant)

When clients, staff from the forensic psychiatric service, and staff from the organisations that clients were moving to all worked in collaboration, the likelihood of success for the transition for the individual was increased.

The next chapter presents the personal journey of adapting to living in the community as experienced by the clients. The categories and subcategories presented in the next chapter have connections with the categories and subcategories presented in this chapter. The processes which affect the success of the transition, such as the apparatus and the personal journey of transition by the clients, inevitably overlap and influence each other.

8 REGAINING AUTONOMY IN A NON-AUTONOMOUS ENVIRONMENT

This chapter presents how clients transitioning to the community strived to regain their autonomy, often in an environment which was non-autonomous. The apparatus, presented in chapter seven, impacted on how each client regained their autonomy while living in the community. Though staff used strategies to help overcome the apparatus, for the clients, each journey to believing they were instrumental in their regaining a life worth living, was personal. Multiple components made up and contributed to the development of autonomy and the clients' transitioning needed to take an active role in this development.

There are four categories presented within this chapter, *Building Self-Determination*, *Inner Thinking: A Reason for Being*, *Outer Thinking: Looking Towards the Future*, and *Getting Through It*. This chapter begins by presenting Building Self-Determination which offers key components the clients needed to develop to become self-determining. The second category, Inner Thinking: A Reason for Being involves the three areas of people, communities and activities, which enabled the clients to see a purpose for themselves. Third, Outer Thinking: Looking Towards the Future presents the key areas which were influential in the installation of hope for the clients for their future. Last, Getting Through It presents the ways clients got through this often-turbulent process of regaining their autonomy.

BUILDING SELF-DETERMINATION

For the clients moving to the community, one of the most significant aspects, which was continually being developed, was their ability to be self-determining, that is, determine and direct their future, as they would like to see it, and participate in it, for themselves. Multiple barriers to being self-determining, such as stigma and discrimination, labelling, and Otherness were presented in chapter seven as part of the apparatus.

External pressures, and rules and regulations which governed how each client could move out of the hospital ward, all overshadowed any personal choice a client may have

had in determining their future. Clients needed to believe that they had a part to play in determining their destiny, but this took time and was fraught with setbacks and challenges. A successful transition was dependent upon the development of attitudes and abilities which enabled a person to determine goals they would like to achieve for the future.

For the clients, determining whom they were and whom they wanted to be for their future was an important step in building self-determination, including finding their voice and deciding when to use it. Clients also needed to have confidence in their decision-making for the development of future-focused goals. Three subcategories were constructed: *Developing a New Sense of Identity*, *Taking Control of Their Voice* and *Making Decisions*.

Developing a New Sense of Identity

Knowing themselves was an integral component to self-determination and was something that did not necessarily come easily to clients. Recognising their changing sense of identity, that is, being able to recognise how they may have changed and developed took self-reflection and could pose difficulties for clients. Being labelled a forensic psychiatric client often contributed to how the public defined clients, which was frequently negative. The clients themselves did not see the same label as important and wished it could be removed.

Being a contributing member of the community was a central aspect to the client participants' transition, and how this looked was unique for each person. For some, like client participant Peter, it was important he was labelled as a worker, someone who could hold a job and was actively participating in the employment sector. This provided him the opportunity to gain financial reward which then gave him choices for his future, along with being a productive member of the community and managing his stigma. Peter had spoken of his desire to work throughout all his interviews. He recognised paid employment helped him remain well and was an important aspect to how he saw himself.

For client participant Sebastian, viewing himself as giving back to the community was an important identity for him. For this reason, he joined a community group which focused on supporting members of the public financially, and he was actively engaged in a range of activities which included talking to nursing students and youth groups

about living with mental illness. He saw this work as being an important part of addressing stigma and discrimination for others, like him, living with mental illness. Sebastian noted:

Talking to the groups I think it's just breaking down that stigma of mental health that some people can get. Like my youth group, they don't know anything about mental health or anything till I tell them.

Sebastian (third interview)

Like the other client participants, Joe was also in the process of developing a new sense of identity. In the past, Joe participated in theft-type offences, and had spent considerable time in prison as a result. Joe no longer saw himself as that person. He now saw himself as a person who would keep away from his previous behaviour, in fact Joe now saw himself capable of contributing to his community. Joe now defined himself as a non-offender and this was an important part of his self-identity:

Confidence to stay out of trouble, you know, like it's been a big part of my life getting in trouble all my life and then being free, you know even when I go into a shop I still feel like pinching something but I stay away from it, so I'm really confident there.

Joe (third interview)

Both staff and client participants described the process of transition as an opportunity to become the person they would like to be. This process did not finish when the person went into the community, it was ongoing and there were many challenges between voicing who they would like to be and becoming that person. Challenges included finding acceptance within the community to which they were moving, having the confidence to engage in the variety of opportunities overviewed in chapter seven, and the challenge of potentially becoming socially isolated and not accessing the support they needed.

Taking Control of Their Voice

Moving into the community involved a process of gaining their voice and determining when and when not to use it. For many, while in the hospital ward, it was difficult for clients to question what staff were doing, or to voice either their disagreement to

decisions being made or to have an opinion on a topic they may have been asked about. During the process of transition to the community the clients were encouraged to develop their voice. Staff participant Ash explained seeing this skill being developed during the transition to the forensic NGO with clients she had supported.

It's about being able to speak for yourself, finding your voice again and when I say find your voice again, it's, you know what you want to say up here [Ash then pointed to her head] but it's getting it out, it's like your vocal cords aren't engaged with your brain and it's getting that back again.

Ash (staff participant)

What Ash was saying was the clients were encouraged to become more autonomous once they had begun the process of moving out of the hospital ward. This process took time, took encouragement from staff, and occurred when the clients' confidence had developed.

When clients arrived at supported accommodation, such as the forensic NGO, there was a certain amount of compliance. This was because clients were excited about not being on the hospital ward anymore, which was usually open rehabilitation ward. They were more willing to engage in all activities because they wanted to stay out of the hospital ward. As time progressed, however, those same clients became more comfortable and confident, and they then started to exert their own personal choices with regard to what they would like to do. Sometimes this was in conflict with what staff believed they should be doing.

Staff participant Dale spoke about a number of clients who were now expressing their voices and autonomy by not agreeing with the staff and making decisions that were about what they wanted to do. These clients now had the confidence to follow through with what they wanted to do and would advise the staff of this. Dale explained:

They'll come in for medication and we'll suggest something needs to be done or we'd have a time booked with them and they'll not see it as a priority because they've got other things to do with friends or church activities or doing their things, running their own errands.

Dale (staff participant)

Client participant Joe developed his voice over his transition. He told of having to speak up regarding an activity (the activity is not disclosed to protect Joe's identity) that was being held at a location he did not feel comfortable with. Joe had spent considerable time participating in the activity in that location and had felt afraid every time. He had managed this fear through medication and increasingly he wanted to stop attending. Using his voice took a lot of confidence; he was not able to merely advise staff he wanted to change his plan but rather he had to justify his choice to a range of staff as to why he wanted to stop attending. He told me he did not believe they were pleased with his decision but he kept persisting and as a result he was able to change his plan. Joe explained:

And I said, no I won't be going. I had to be assertive.

Joe (third interview)

Joe's voice was successful. He was now engaged in the same type of activity, just in a different location. Joe had always wanted to complete the activity, just not in the original location. He reported being very enthusiastic about the activity as he believed it was benefitting him for his future.

Client participants also spoke of needing to monitor their voices too because of the perceived negative impact on their progression through their transition. Making decisions on when to use their voice also included when not to use it. Joe believed at times he used his voice too much and as a result he had spent longer on the hospital ward than he believed he needed. Joe spoke about the times he had disclosed how he was feeling, such as his paranoia, and he believed as a consequence, he had spent more time on the hospital ward than he believed he needed to. Joe was now mindful of monitoring what he said to staff because of the potential for impact on his liberty. Joe explained:

What I've learnt over the years that you can be open and talk to the professionals and you can actually say a bit too much too, yeah. They can sort of use it against you, yeah.

Joe (third interview)

Client participant Peter was aware that his belief in Reiki¹⁹ was in conflict with his clinical team. He believed if he told his clinical team about his belief in this healing practice then they would likely believe he was becoming unwell and he would have a change in his medication. So, Peter had not disclosed this to his clinical team. Taking control of their voice was developed by the client participants over the process of transition. For some, having the confidence to speak up was developed, while for others, learning how to curb the use of their voice was fostered. Client participants recognised taking control of their voice helped them to determine their future.

Making Decisions

Developing confidence in making decisions, for their future, was an important part of building their self-determination for client participants. During the process of moving to the community the freedom to make decisions about a range of topics for themselves increased for the client participants. The types of decisions included what and when to eat, what activities to participate in, when to visit friends, and when to get up in the morning. Though the clients were encouraged to look at their future while on the hospital ward and to engage with the decision-making process many of the client participants believed they only truly became able to make decisions for themselves when they were out of the hospital ward confines. Even then, some staff would, at times, choose to disregard the client's decision and instead make substitute decisions for the client. Staff would do this because they believed they were protecting the client from possible failure or because they needed to protect others.

Many of the everyday decisions that most people take for granted where the decisions that had the most significant impact for clients in transition, such as deciding what they would eat for their meals, when they might like to eat their meals and snacks and when they would visit friends, were all decisions they could make when they had left the hospital ward. Learning to make decisions and choices took time. When clients were spending increasing lengths of time within the wider community, the client participants had the ability to consolidate this skill of making decisions, as they had increasing exposure to a range of opportunities that required their decisions.

¹⁹ Reiki is a form of alternative medicine which promotes healing and is used for stress reduction and relaxation. It is based on the idea that an unseen "life force energy" flows through a person so is administered by "laying on hands".

Those client participants who went to the forensic NGO accepted the decision that they would be going to this situation with full-time support. Most were enthusiastic about the opportunity, because they saw the increase of freedom as being something they were striving for. To a certain extent their decision could be seen as a forgone conclusion as their choice was to either remain on the hospital ward or undertake transition to the supported accommodation. Sebastian and then Peter explained that their reaction to supported accommodation was not as much about going to the supported accommodation per se, it was about leaving the hospital ward:

I was quite enthused about it. You know the whole concept of getting out of hospital and getting in here.

Sebastian (third interview)

I was really looking forward to getting out of the ward, yep, I don't like being in the hospital, on hospital grounds, in the ward.

Peter (third interview)

Client participant Harry was still a prisoner, who was in the forensic psychiatric hospital ward, so he had not yet visited any possible accommodation placements. Harry recognised he would need accommodation with on-site support when he left the hospital ward because it had been a long time since he had lived in the community and he was aware of his need, initially, for a high level of support. When discussing possible options for accommodation with Harry during his interviews, Harry identified he wanted to stay in his current city but did not identify any specific preference for where he would live, rather, he deferred to the staff making this decision for him. Harry said:

I'd like to remain in [main city], so it's, got to be something suitable within [main city] really and I don't know what that is Well I've have a case manager out at the prison so he's working with a few things at the moment, I'm not quite sure what they'll be.

Harry (third interview)

Harry knew he needed a high level of support but believed the staff from the correctional service, with input from the forensic psychiatric service, would be better situated to make the decision on which accommodation he would go to.

Another client participant Smelly was enthusiastic about moving to his supported accommodation as he was not required to complete everyday domestic tasks such as cooking and cleaning. He preferred not to do these tasks. Smelly was not going to the forensic NGO but rather to accommodation which was regarded as a home for life and seen as similar to a rest home for clients with major mental illness. Smelly was not anticipating moving on from this accommodation in the future. Though the decision to refer Smelly to this accommodation was made by the staff from the hospital ward and Smelly initially agreed as he wanted off the hospital ward. After spending increasing time at his new accommodation Smelly began to see the benefits it had for him and by his third interview Smelly was actively verbalising his support about the decision for him to go there.

Client participant Sebastian was offered supported accommodation at an NGO by the staff within the hospital ward. He was very reluctant to go to that accommodation because of his previous experience with it and from what he had heard from others. Sebastian refused and specifically requested the forensic NGO because of feedback he had heard from other clients. He believed the forensic NGO would better be able to support him integrating into the community. Sebastian stated:

I didn't want to go to [supported accommodation]. Cause, I've heard they've got some dodgy people in there. Looking at some of their cliental [supported accommodation], I didn't want to bother with them. I also think because [forensic NGO] has opened up for Special Patients. So, I went and had a look at [forensic NGO] and I thought, yeah, I like the look of this place.

Sebastian (walking interview)

By the end of the data collection phase of the research Sebastian was living six nights a week at the forensic NGO and was happy he had not been transferred directly into an independent living arrangement.

Sebastian also spoke of the importance of making decisions for himself early into his transition. The forensic NGO was a place he could become confident and familiar with making decisions. Having the support readily available helped build his confidence, because he could check out with staff when he needed to. He, like the other client participants, believed his active involvement in all aspects of his transition increased the likelihood of his success.

I think it's important that you get to make your own decisions. Rather than have everything done, decided for you. To actually be able to turn round and say "yeah well that's a good idea, we'll go with this" or "no I don't agree with that at all, so I'm not going to do that".

Sebastian (interview three)

Clients, who had spent many years in an environment constrained by multiple structures, were required to develop skills which enabled them to be self-determining about their future. For Sebastian, Peter and Joe, this was possible. For Smelly and Jae, it was problematic at times, and for Harry, his choices were governed by the Corrections service. Regaining autonomy in a non-autonomous environment required a person to be thinking about themselves and understanding why they were in the world.

INNER THINKING: A REASON FOR BEING

Clients having a reason for getting up in the morning, being able to see a purpose for being in the world, was regarded as important for regaining autonomy. Each client needed to believe they had a place in the world in which they lived. For those integrating into the community it was an opportune time to re-evaluate events from the past and to make changes for their future.

Connections to a range of people, such as family, friends and professionals, played an important role in helping the clients transitioning believe there was a reason for them being present in the world. Along with needing others to be connected to, there was also a need to be connected to the range of communities in which they were involved with and making contributions to those communities was a way of facilitating connections. Finding meaning in what they were doing provided a sense of purpose for those transitioning. Together, these connections to people, places and occupations, provided a reason for being in the world. Three subcategories were constructed: *Being*

Connected to People, Contributing to Their Communities and Finding Meaning in What They Do.

Being Connected to People

Transitioning for the client participants was not a socially isolated process. All participants, both staff and clients, verbalised a need for clients to have connections to a range of people and those connections needed to be reciprocated. This helped establish a reason for being. The connections to people, such as family, friends and professionals, who were trusted helped the clients transitioning feel safe in their community. Being connected demonstrated the person transitioning was trusted, was able to take responsibility for the relationship, and was a contributing member of the relationship. Being connected to other people was also an important aspect of maintaining their wellness.

Family was the most significant group of people the participants talked about as being important during their whole transition. Family provided much support during this time and having a reciprocal connection was important. The type of support families provided varied for each client and could include a listening ear, financial top-ups and opportunities to spend time away from health professionals. A number of client participants spoke of their desire to give back to their families. They recognised the support that had been given to them over the years and wanted an opportunity to reciprocate. Client participant Joe spoke of his desire to support his mother, especially since she had supported him continually over the years. Client participant Peter spoke of his desire to spend increasing time with his family, to enable him to fulfil the role of being a brother. Client participant Smelly spoke of his enjoyment of spending time with his parents as it was an opportunity to keep connected to the other members of his family. Client participant Harry believed as his parents were aging he should reciprocate the support they have provided him over the years.

I think family is important, I just think, especially when you've been out of society for a while and you, especially when I go back to prison and that sort of thing, you know they were there to support me, so, it's sort of

a reversal thing now for me, I've got to be there for them too and I think that's very important because my parents are getting older and it's time to give back to them.

Harry (third interview)

The second group of people important to clients transitioning were friends. Most were also people who had come through similar journeys so it was easier to connect with them because of the common experiences they shared. Being a friend and supporting those who were on a similar journey was also an important part of finding their place in the world. When client participant Joe was asked about who the important people were who supported him during his transition to the community he advised his friends were significant. Joe's friends were predominantly people who had similar journeys to himself so they could relate to what he had gone through. Joe said:

Friends are, well in the mental health system, friends are in there, mainly cause, you know, they've got something wrong with them as well, schizophrenia or depression or something. So they can sort of relate to your case because they've got similar sort of symptoms and you can talk to them as well, have a joke with them.

Joe (third interview)

The client participants also said it was also important to spend time with friends and to provide a helping hand when necessary. They said they did not want to return to friendships from their past that were regarded as detrimental to their health and well-being but it was important to nurture the friendships that supported them and they could reciprocate with support for them.

Client participant Peter spoke about recently being helped by a friend financially. His friend had given him money to help with an expense he had recently incurred. Peter explained he had done the same for his friend in the past and that was what friendship was about for him. Peter explained:

I've looked after him in the past. What goes around comes around.

Peter (walking interview)

For client participant Smelly, staying connected to his friends was important as it helped him stay connected to the wider community. He ran the risk of being isolated from what was happening in the wider community if he did not maintain his connections to his friends. Smelly spoke in short, stilted sentences during his interviews; however, he was clear on why friends were important to him.

Staying in contact with the world.

Smelly (third interview)

Client participant Harry articulated why friends were important to him and how they helped him to refrain from reverting to behaviours which were not good for his health and well-being:

Well having a network of friends and not reverting back into that old pattern of being alone that sort of thing. I think the more social you are the more adaptive you are to society. If that makes sense.

Harry (third interview)

It did make sense and staff participants agreed. They talked of the importance of friendships for their clients. Social isolation had a negative impact on successful transition to the community and being connected to people who had been through a similar process was important for success in the community. Staff participants noted that having reasons for leaving the confines of their flats, opportunities to connect to people they enjoy spending time with, and participating in a range of activities with others, all helped clients with the transition process. Together, connections with family and friends helped maintain clients in the community. Staff participant Alex explained:

I have bumped into different patients that I've looked after over the years and yeah, they've connected back up with family and friends and they've out there still, which is good.

Alex (staff participant)

The third group of people who were important to be connected with were the professionals who were part of the transition process. The client participants recognised the contribution the professionals had made to their progress. Professionals

included the clinical staff in their lives, the staff of the range of organisations the client was involved with and people such as employers for those who held employment. Trusting and being trusted by this group of people was important when forming connections. Being responsible and taking on that responsibility to others was an important factor for many of the client participants.

Client participant Sebastian talked about his work and his connection to his boss. His relationship with his boss was based on trust. Sebastian described times where he was left with the responsibility for his workplace because his boss believed in him. His boss did not berate him when he had made mistakes because he had already proven himself a good employee and this helped facilitate the connection they had. Sebastian said:

I got a really good boss, you know, getting a good boss like that is hard to come by.

Sebastian (interview three)

There was a wide range of professionals the client participants engaged with during their transition to the community and some of those professionals did not prove to be supportive or helpful during this process. Client participants spoke of their anxiety and reluctance to engage with a range of staff from organisations such as Work and Income New Zealand (WINZ), banks and employment services because of how they were treated. The client participants perceived they were often disbelieved when talking about their situation. As a result, they found they were not able to speak clearly or coherently at times and ended up feeling frustrated and unheard.

Client participants relied on the staff from either the forensic psychiatric service, the forensic NGO or other support staff to accompany them to these appointments. The staff would speak for the clients to ensure they were able to access their entitlements. With the support of the staff they trusted, the client participants' confidence in communicating with these organisations increased and during their transition their reliance on the different staff reduced. Client participant Sebastian gave an instance when he worked with WINZ: his confidence and his independence had developed with the support of staff and he was now able to complete aspects of setting up an appointment with WINZ by himself. Previously, he had required staff to complete all these aspects. Sebastian said:

I was the one that did it, you know, and I think the first thing I did, when I was here by myself, was couple of things with WINZ, so I booked the appointment and I mean, I had a peer worker go with me, but I basically got all, filled out the forms and got all the information ready myself and booked the appointment, went in and I thought, yeah I did that.

Sebastian (interview three)

Connections to people was an important aspect for clients finding their place in their world. Connections represented trust, responsibility and reciprocity and it was important for those transitioning to the community to know they had people to rely on and that they were also contributing to the relationship.

Contributing to Their Communities

To live successfully out of the hospital ward, it was important for those transitioning to have connections to the multiple communities which they were a part of. The forensic NGO was often the first community joined by clients leaving the hospital ward, and for those who had moved out of the forensic NGO, the flat they were now living with others was another community.

Some of the client participants were involved in community groups, sporting groups, religious and spiritual groups, and employment communities. One of the ways of becoming connected to those communities was when the clients believed they were contributing to these communities.

Client participant Sebastian spoke of the importance of contributing when he decided to join a local voluntary organisation. He believed it was important to give back and he could do this by being part of the group. He took great pride in describing the range of activities his group had helped fund for individuals:

I do like the idea of, yeah, charitable part of it all and that there and getting out there and helping people and that, yeah.

Sebastian (third interview)

Paid employment was another way that those transitioning could demonstrate their contribution to the community. For many of the client participants, they had an expectation they would find employment when they left the hospital ward because it

was their belief society expected that of them. Client participant Smelly believed once he had moved out of the hospital ward he should be finding work. This was an expectation he had of himself and though he was busy writing a computer programme while on the ward it was not something he thought he should focus on when in the community.

I could still work on it while I'm there, but I really should be going out to work.

Smelly (walking interview)

Other client participants communicated the same desire to find work once living in the community. The financial gains from employment would then give them independence and they would then be less of a burden on the wider community. Employment was important as it enabled clients to see themselves as being productive members of society and thus being able to see their reason for being.

Finding Meaning in What They Do

Both staff and client participants spoke of the importance of engagement in activities that were both purposeful and meaningful to the person, not just during transition but also for the long-term success of living in the community. When the activities were both purposeful and meaningful the clients had a reason to get out of bed. Having activities in which the clients enjoyed participating often helped facilitate connections to the place the activities were occurring and with the people they were completing them with. Engagement in specific activities, such as employment, helped clients define who they were and how they saw themselves. Actively participating in meaningful activities were also ways clients used to distract themselves from ruminating on their past or worrying about their future. Client participant Harry explained by engaging in an activity he was able to focus on the present, focus on what he was doing at the time and this stopped him worrying about what had happened in his past or what might happen in his future. Harry said:

Well you know you're not sitting around thinking about the past or what's going to happen in the future. You're actively engaged in,

mindful of what you're doing at the time. Yeah, I just think activity is very important.

Harry (interview three)

Staff also worked to ensure their clients had meaningful activities that they could regularly engage in and which were not a burden on them financially. Staff participant Alex noted:

Having some meaning in their day. Whether that's going out, having some real meaning, whether it's just going for a walk, or doing some voluntary work or walking dogs for people or going and visiting someone, having a purpose, getting them out of the house.

Alex (staff participant)

Alex was saying how important meaningful activity was for the clients to engage in. The activity was an important way for clients to find meaning in their day and it helped provide purpose for them.

Several client participants were aware of being too busy. Sometimes, not having time to relax was detrimental to their health and well-being. Engagement in activities was a balancing act between being overstimulated and becoming bored. Client participant Jae was aware staff wanted to structure his week with a range of activities; however, he found he also needed time to make his own decisions about how to fill his day. Sometimes that also included sitting in his flat, just having time out. Jae said:

I feel, I think it's a good way, good way to keep me occupied, but I don't like being occupied too much.

Jae (interview one)

Jae explained how he enjoyed sitting in his flat and taking time out of his busy schedule. Often, doing this conflicted with what staff had planned for him.

There was a range of activities the clients transitioning engaged in that were meaningful to them. One of the most significant that all participants spoke about was that of employment. Employment, which was discussed in chapter three as being important for community reintegration, offered many benefits for those transitioning.

The financial reward allowed freedom to purchase items that would not otherwise be affordable; it gave clients options on what they might like to participate in. For those in employment, one of the most valuable benefits related to how a person felt about themselves. Being able to contribute to the community in which they lived, seeing themselves as a productive member of society, and being able to support family and friends, were all factors client participants spoke of. Staff participants also spoke of how clients' demeanour and self-confidence increased when they were engaged in employment. For this reason, locating employment for the clients who both wanted and were able to work was a focus for the forensic psychiatric service. Client participant Peter explained the staff in his clinical team focused on helping him into employment because they were aware of how important it was for his well-being. Peter knew that having employment helped him feel settled mentally. Peter described the effort he and his clinical team took to look for work:

They [the staff] are really conscious at getting me working cause they know I function better when I'm working. So the OT would have me working all the time, searching for jobs, going to different job agencies. She'd take me and we'd have interviews. Get my CV together, yeah.

Peter (interview one)

For others, employment was not an option; some clients found work to be highly stressful and this had a negative impact on their health and well-being. Client participant Joe spoke of his reluctance to move into employment at this stage of his transition owing to the increased anxiety he experienced and the negative impact anxiety had on his mental well-being. Others were unable to go out to work at that time owing to legislative constraints, such as client participant Harry; however, he was very clear, that once he was able to, he wanted to find work to support himself.

Finding employment in the community posed many hurdles for forensic psychiatric clients. A number of the client participants had been supported through a range of educational training programmes and had obtained a range of trade qualifications in an effort to find jobs. However, securing a job in this area posed difficulties. Staff participant Sam spoke about his belief about why these clients were still not employed. He did not believe it was because of a lack of qualification but rather because they

disclosed to potential employers they were within the forensic psychiatric service. Sam explained:

I think there's some community fear. We encourage our men to disclose, so that they can live without looking over their shoulder. That's one of the values that we espouse to them and I think that has not, I think has been against them. I think that hasn't been in their favour.

Sam (staff participant)

Other areas of meaningful and purposeful activity included completing everyday activities such as cooking and cleaning. These activities were often taken for granted by the general population; however, it was during the process of transition that this group of clients returned to these everyday activities. Many had been in the hospital ward for several years and had not had the opportunity to engage with these activities for a very long time. During his first interview, client participant Sebastian was still spending most of the week at the hospital ward. He had not had recent experience with everyday activities such as cleaning a shower, cleaning a toilet or mopping a floor. He was keen to complete these tasks because he regarded them as being part of living successfully in the community. However, he needed support from staff to help him re-engage with these activities. Sebastian explained:

Well [forensic NGO] is pretty good in the fact they give you a lot of support and one of the supports they give you is cleaning support where they come in and check your flat out and help you clean it and sort of like your shower and your toilet and stuff like that, which you don't really do here. Well you clean your room and you do your washing but the rest of it you don't do you know, you just, the cleaner does it, so next when your there and you think aww heck I've got to mop the floor, got to clean the bench, I've got to clean the toilet, clean the sink.

Sebastian (interview one)

During his third interview Sebastian spoke with pride when he described how he now required less support from staff in regard to his cooking and cleaning as his skills and confidence had grown. Sebastian was now living six nights a week at the forensic NGO so his practice in completing these tasks had improved his confidence. The range of

activities the clients transitioning to the community find meaningful was wide and varied. What was important was to find activities for those transitioning that would bring meaning and would enable them to see their reason for being.

Having a purpose and reason for getting up each morning was important for those transitioning to the community. Connecting to people, contributing to their communities and finding meaning in what they were doing were all interrelated and enabled those transitioning to the community to see their reason for being. Looking towards the future and knowing what they wanted to work towards was also highlighted as important to regaining autonomy.

OUTER THINKING: LOOKING TOWARDS THE FUTURE

The prospect of having a future outside the hospital after many years of being within these confining structures was very exciting for the client participants. Looking towards the future, for clients transitioning, involved recognising the meaning freedom held for themselves and how it was linked to their hopes and options for their future. Hope required nurturing and fostering otherwise it was replaced with frustration and anger, which then lead to despair and a lack of engagement with staff. Clients who were transitioning could see that the freedom they were gaining would enable them to obtain the future they hoped for.

Goals the clients held could be achieved, as long as they had the skills and competencies required to make sure long-term community living was successful. Living in the community required a person to continually engage in an adaptation process (see chapter two), as changes continued to occur, and being able to adapt to such changes increased the success of living in the community. Three subcategories were constructed: *The Meaning of Freedom*, *Having a Plan* and *Building Capabilities*.

The Meaning of Freedom

Returning to the community held many meanings for the client participants and one of the most significant was their perception of freedom. For the client participants increased freedom equated to increased options and aspirations for their future. Each client had unique hopes for their future. Knowing they had options for their future was what was important for the clients. Many of the options identified by the participants included finding paid employment, making decisions on where they would live and

whom they would live with, how they would fill their day and what they might like to do to relax. Client participant Smelly, who was transitioning to the equivalent of a rest home, saw the options available to him after leaving the hospital ward as being for him to make as he wished:

Pretty much do as I please.

Smelly (interview one)

Though Smelly was transitioning to another environment, one that was structured, he still believed he would be able to participate in activities he wanted and that were instigated by him.

For many of the client participants, their first experience of freedom was living in the community at the forensic NGO. Moving to this accommodation was an increase in freedom from the hospital ward structure and so options were increased. However, the supported accommodation had rules which all those living there were required to follow. Taking of medication was the clearest all clients were expected to follow. They were required to be present at set times every day to take their medication. If they did not turn up or did not communicate with staff from the forensic NGO, then their clinical team were likely to be involved promptly. All clients were also required to advise staff from the forensic NGO if they were leaving their flats and to let them know when they had returned. Clients were not required to ask permission to leave; however, owing to health and safety requirements, staff were required to know who was on site all the time. This meant any visitors were also required to sign in at the office. Over time, the client participants reported feelings of frustration with some of the rules. Though they had increased freedom and options compared with the hospital ward, they were still not able to take advantage of all options they would like to. Client participant Peter was looking forwards to moving into a flat of his own, one that he could share with a flatmate. He could articulate some of the benefits he perceived from the increased freedom of living outside the forensic NGO. Peter commented:

Being able to have friends over later. Because here we've got like a 10 o'clock curfew. Friends are only allowed, they have to be gone by 10

o'clock. So if I want to sit down and play Playstation all-night with my mate on a Friday night I can.

Peter (interview three)

Hope, and specifically the hope for a future they wanted, was central to the success of the transition. Each person needed to be able to envision that their future would be the way they would like it to be, rather than one that had been orchestrated by someone else. For some, the hopes they held for the future were not necessarily seen as priorities by staff; rather, sometimes these hopes were viewed as unrealistic. Client participant Jae held hopes he would perfect his sporting skills and wanted to become a team sports player and be recognised as talented. Client participant Sebastian's hopes for his future related to living successfully with no on-site support in a flat in his current city, and owning a dog again. Client participant Harry conveyed a hope that was representative of what the client participants all conveyed within the research:

Well hopefully working, earning an honest day's living, yeah, keeping myself busy, spending time with my family

Harry (walking interview)

Staff participants advised that the hopes of those transitioning were not dissimilar to those of the general population: wanting to have a safe place to live, wanting people to be connected to, meaningful and purposeful activities to be involved in, and especially being able to hold down paid employment. Sam explained:

Often the client says they just want a car, a job and a girlfriend. You know, and gee that would be wonderful you know.

Sam (staff participant)

Hope needed to be nurtured and fostered otherwise feelings such as anger, jealousy and frustration replaced hope. For those individuals transitioning to the community, seeing the freedom they were gaining led them to believe they could obtain the future they hoped for.

Having a Plan

Looking towards the future included having plans for that future and each client participant was able to articulate what that was for them. Many of the plans the client participants held were long-term goals rather than based around their immediate future. However, they were all able to articulate how they saw what they were doing in the present as working towards their long-term plans.

Future locations of where they would live was a common plan for the client participants. For some, those plans were about specific locations, such as staying within their current city, while others planned to move closer to where their families were living, the geographical location being irrelevant; what was important was that they were near their family. Staying in their current city was relatively simple because they already had staff available and a range of networks had been created to provide necessary support. For the clients who wanted to leave, they were aware that this would take some time. Some client participants advised they did not voice this desire to their clinical team because they knew staff did not support that plan. Peter, during his walking interview, spoke of where he would like to live in the future. His plan related to the type of area he wanted to live in the city rather than a specific location. Peter was aware that the area we were walking through was not a low socioeconomic area because of the type of houses we were seeing. While walking past houses in the suburb he lived in, he pointed out places he admired. To Peter, these houses represented a status of doing well and safe places to live to him. Peter said:

Yeah, a lot of middle class people around here. They're not impoverished so if you were living in [suburb] or [suburb] they don't have much in those areas so you can expect your sneakers to go missing off the doorstep.

Peter (walking interview)

Peter had a plan to one day live in a similar area, because that would represent he had been successful.

Not all plans were supported by staff. The staff participants spoke of the goals their clients transitioning were currently focusing on. They also spoke of the importance of having a focus for the future, though that was tempered by some of the staff

participants who needed the goals to be what they viewed as realistic. Determining whether goals were realistic appeared to be decided by the staff. Staff participant Dale spoke about clients who had identified future goals that they believed appeared to be unobtainable in the client's current situation. A client had identified a goal for their future but after it was discussed with that client's clinical team the goal was removed from his plan by staff. The decision was made to include another goal which was deemed, by the staff, as more obtainable for the client at that moment. Dale explained:

One of his goals was to [complete a specific activity] and that goal was put down and then we discussed with the clinical team and we decided that the goal was obviously, probably out of his reach. He's not exactly capable of doing that at the moment so then we have that goal sort of wiped and we'd look at maybe a new goal being a bit more obtainable for him.

Dale (staff participant)

The view expressed by Dale was also was also expressed by other staff participants. The decision to change a client identified goal was based on a paternalistic view the staff did not believe the client was capable, at that stage, of being successful in their chosen goal. Changing the goal was a way of protecting the client from what the staff perceived as failure. There were a number of examples where staff appeared to have difficulty accepting clients' decisions and instead of engaging in a supported decision-making process the staff overrode the clients' decisions.

Client participant Sebastian had experienced his goals being changed by staff. He spoke of his desire to one day attend film school to fulfil his dream of creating a studio where he could create a small business which would make television commercials and rock videos. He was aware the staff did not believe this plan was realistic for him and the staff did not believe it should be on his plan. Sebastian remained adamant everything he was currently doing was working towards this long-term goal and he would not be swayed by the staff: Sebastian stated:

Yeah, and they're going "well we don't think that's realistic" and I'm thinking "well I don't really care if you think it's realistic or not that's

what I want to do”.

Sebastian (third interview)

Staff not engaging in a supported decision-making process with Sebastian meant he now kept his long-term goal hidden as he knew staff did not agree.

Overall, the client participants' plans were to remain mentally well, to stay out of the hospital ward, to remain offence free and to follow the rules that had been made for them. They were aware that the medication they were required to take was an important part of keeping them well, along with the other strategies and skills they had been learning and developing along the way. Client participant Joe noted:

My future focus is, to stay well, stay on the medication, it's a big thing, cause in the past when I committed my offence and that I wasn't, not taking my medication. Keep in contact with friends and family, yeah, continuing on being, stick to the road rules, and just moving on from here and staying well.

Joe (third interview)

The sentiment expressed by Joe was similar to that of the other client participants. Staying out of trouble, taking medication and remaining connected with family and friends were the overall goals for each person.

Building Capabilities

There was a range of skills necessary for living in the community. For many, the skills needed for successful community living had been developed previously but because of their situation had not been used for a very long time so returning to focus on these was an important part of transitioning. These ranged from practical skills such as cooking, budgeting and maintaining a flat/accommodation through to broader skills, including coping strategies, problem-solving skills, assertiveness and goal setting.

All the client participants spoke of their need to feel confident in managing their-day-to-day aspects of their lives in the community. Being confident to pay bills, cook meals, keep their flats clean and tidy were skills which required relearning after significant periods of time on the hospital ward. Many of these skills were not needed when living on a hospital ward where meals were tray service, bathrooms and rooms

were cleaned and all bills were paid for. Staff participant Chris commented on the range of skills clients she believed was needed for successful community living:

It's important for them to be able to take care of themselves and that sometimes they forget things like, how to make their bed properly, how to dust a room, how to vacuum, how to do their own washing, you know, and I think that's sort of like plays a big part in transitioning them correctly out into the community. Cause without those skills, I just don't think they're going to like, benefit from it. So I think that's something, you know, that we all focus on here as well.

Chris (staff participant)

The management of money appeared to also be one of the most significant areas of conflict for staff and clients. Budgeting skills were important, especially when finances were tight and the client's priority was to stay in the community. Staff participant Alex had worked with clients in the community who struggled at times to manage their money. Alex described how the clients were often not happy when staff intervened; however, when the client realised the focus was about keeping them in the community, they were more receptive. Alex explained:

They didn't like anyone else having control over their money, they felt that, they were capable of being able to pay the landlord on time, paying their power account, things like that. But then when you sit down and talk to them and say, "you know it hasn't worked out", "this is how many flats you've had and this is how many times you've been into arrears", yeah, and writing it all down and being very, very upfront with them and saying "let's just try this, let's try another way" and, yeah, once they've found that they can stay in their places and that it wasn't really so bad after all.

Alex (staff participant)

Alex believed the management of finances was one of the most significant skills clients needed to have confidence with if they were to live successfully long term in the community.

The stress and anxiety of having a tight financial situation could significantly impact on a persons' mental well-being, and, subsequently, their ability to live well in the community. Having limited financial resources was a significant challenge but when coupled with limited skills in managing finances the challenge was harder. Staff participants had experienced clients deteriorating mentally when they were unable to manage their finances to cover everyday bills such as power, food and transport. Staff participant Dale spoke of a client who was recently moving out of the forensic NGO and into an independent situation and he was unsure how he would cope. Dale said:

He's come so far and he's done so well but financially he's not coping and for him to not have the finances there for normal day to day living and normal tasks that's going to set him back. I can see over time he's going to probably deteriorate. Yep, he's yeah going to be quite stressed, especially recently with the power, finding out the powers going up, we don't know where we are going to get that money from and [NGO service] can't support him with that.

Dale (staff participant)

Other skills clients transitioning began relearning while on the hospital ward and continued to focus on when they went to supported accommodation (such as the forensic NGO) included cooking and managing the cleanliness of their flat. Often these skills were taken for granted by the general population because they were activities completed daily, so they were reinforced regularly. For clients transitioning, it was a matter of returning to the everyday, and what could be deemed as mundane and monotonous by the general population was in fact something to be proud of and celebrated. The clients transitioning could experience a sense of pride from being able to complete everyday tasks for themselves. Client participant Joe experienced this when he cooked his meals at his flat at the forensic NGO. Joe explained:

Oh yeah, just good to do something and say oh I've cooked this and eat it.

Joe (interview one)

At times, the skills themselves were already developed and what was needed was the reinforcement of continuing to engage with them. Supported community

accommodation, such as the forensic NGO, was a safe place for those transitioning to gain their confidence in completing the tasks they needed for living well in their own flat in the community. Client participant Sebastian spoke of the range of skills he believed he needed to live successfully in the community. These skills predominantly focused on the everyday tasks the general population complete, such as household cleaning, cooking meals, and managing his budget. Sebastian saw his time at the forensic NGO as being opportune to develop these skills so that when he had an independent flat he would already be confident in these activities. Sebastian commented:

More independence, well I want to get into the community, I got to do these things by myself anyway. So it's good to get into it now, so when I do go to the community then it's going to be an easier transition.

Sebastian (interview three)

Coping with change was highlighted as a capability required for successful transition and the development of resilience within this research by both the staff and client participants. Change was constant for those transitioning to the community. Leaving the hospital ward to live permanently in the community did not signal the end of the adaptation process. Being capable of managing when either expected or unexpected alterations of plans occurred was integral for those transitioning. As a result, broader skills used in a range of different activities were also a focus for staff supporting those transitioning to the community. Client participants were able to articulate that past coping strategies had not always been helpful and had in fact been detrimental. Much work by clients had been put into making changes and a range of programmes had been offered which supported the development of appropriate skills for community living. One of the client participants, Joe, recognised that his past way of coping had not been successful for him. Previously, he had coped with stress and tension with violence and since being within the forensic psychiatric service he has focused on his anger management and completed a range of courses to help him develop his capabilities. Joe said:

Well I've always, all through my life I've had like a short fuse that I go off sort of, and now being well medicated its sort, of helps me to relax, and not go off and if there's any tension or with anybody or anything I

just walk away or run away. If there is ...but there hasn't been. I've done violence prevention, got about 20 certificates.

Joe (interview one)

Some clients were initially reluctant to engage in the courses and programmes. Clients participated because they believed they had too. However, after seeing their progress they acknowledged what they had learnt in these courses had helped them with their transition out of the hospital ward. Client participant Peter initially felt pressured by staff to complete the courses. Peter advised:

Oh, well I got made to do assertiveness courses, communication skills, three times, I had to do drug and alcohol relapse and then I've did like a violence prevention course, did a parenting course through Plunket, just all different courses they made me do.

Peter (interview three)

Peter went on to explain he could now see how these courses had benefitted him with his transition and believed his success could, in part, be attributed to what he had learnt.

Each client used personalised ways managing the stress and uncertainty of getting through the transition process. Making decisions about what would work for them was an important way of regaining their autonomy.

GETTING THROUGH IT

Getting through it refers to the range of strategies the clients used in an attempt to manage their transition process. Looking after themselves and doing what they had to, to ensure they survived the transition was an important factor for a successful transition. Each person had their own unique strategies that were used when they needed it. Getting through the transition process in a manner which met society's normative expectations helped demonstrate both to the clinical team and members of the public the clients were ready to be back in the community and that they belonged there. For each client ensuring they got through the transition helped ensure success in living in the community.

The time taken to move out of the hospital ward completely was often dependent on the type of legal requirements each person must work within. Clients transitioning became

experienced in waiting. Waiting for legal processes to be completed, for review outcomes to be made known, for boxes to be ticked and t's and i's to be crossed and dotted. Biding their time became commonplace for many of those transitioning while waiting for decisions to be made that were out of their control. In many instances the clients transitioning developed strategies to enable them to survive this process, to keep themselves focused on getting through the transition so they could get to where they would like to be in their future. Getting through it involved patience and two subcategories were constructed, *Marking Time* and *Surviving*.

Marking time

Waiting was a familiar concept for those transitioning within forensic psychiatric services. Owing to legislative requirements, the transition process to the community could not happen at the speed most of the clients would have preferred. Often the clients played a waiting game while hoping the red tape that was holding up their progression was removed.

Five of the six client participants were under Special Patient status meaning that authorisation for increased access to the community needed to come from groups of people outside of the clinical team. This, then, meant waiting for approval to come before any changes could be made to current transition arrangements. During his first interview, client participant Sebastian was spending most of his time at the hospital ward, though he was transitioning to the forensic NGO. He was waiting to hear if his increase in leave was going to be successful which would allow him to spend six night a week at the forensic NGO. Sebastian was aware his clinical team had supported the increase in leave but because he was a Special Patient the authorisation had to come from the Ministry of Health. Sebastian was familiar with biding his time. Sebastian explained:

Pretty shortly, once everything, starts rolling on, cause again as I said being a Special Patient I've got to go through the Ministry of Health and they've got to sign it off. So that takes a couple of months on its own to get done.

Sebastian (interview one)

By the time Sebastian was completing his walking interview, he had been successful in obtaining increased leave from the Ministry of Health and was now living six nights a week at the forensic NGO. He was anticipating he would need to wait for at least a year or more before he could apply for Ministerial Long Leave which would allow him to live in the community seven nights a week.

Some client participants spoke with a level of resignation and some frustration about the fact that people and organisations had control over the timing of any increased freedom and the time it took to gain approval. None of these client participants could move from the hospital ward to the community in one go. Most had built up their leaves to the community for six nights but were required to return to the hospital ward one night a week for extended time before being able to apply for Ministerial Long Leave, which would then allow them to live permanently in the community without the need to return to the hospital ward one night a week. Client participant Peter endured returning to the hospital ward each week and was merely waiting to gain the leave he needed.

For other client participants, waiting was not something to be concerned about. Joe, who was within the forensic NGO and required to return to the hospital ward once a week, was aware that he was likely to have to wait another 12 months before he would gain Ministerial Long Leave. He had been within the hospital wards for ten years and he saw potentially waiting for another 12 months before he could stay seven nights a week in the community as being insignificant in the larger scheme of things. Joe commented:

Well I've done 10 years so another year is not going to, it's nothing really compared to 10.

Joe (interview one)

After the completion of data collection, Joe learnt he had been granted Ministerial Long Leave, which had occurred quicker than he had anticipated, and meant he no longer had to return to the hospital ward and was now able to find an independent flat in the community where he could live with a flatmate.

Client participant Harry remained a prisoner and was waiting to apply for parole again. There were a number of changes to his transition he wanted, however, he was required to have gained Parole prior to these being possible. Harry was aware that his clinical

team was supporting the changes and supporting him in his application for parole; however, he was required to wait for staff within the Corrections service to make decisions. Harry was unsure how long the staff at Corrections would take to make their decisions or what the decision would be. Harry explained:

Well I've had a case manager out at the prison so he's working with a few things at the moment, I'm not quite sure what they'll be.

Harry (interview three)

Like Harry, biding their time and waiting for decisions was something the client participants were very familiar with. Most were resigned to having to wait, some experienced frustration, while others were happy to wait because they saw the time that the decisions took to be made as insignificant compared with the time they had already spent within the hospital wards.

Surviving

Looking after themselves and doing what they had to, to survive, was an important aspect to a successful transition for the client participants. Many of the client participants talked about ways they took time out, took time to think, which enabled them to process the changes that had occurred in their lives. It was an important part of adapting to living in the community again. Client participant Peter used the walk he had regularly completed in the past as part of his walking interview. The walk was something he completed as a way of clearing his head of any negative thoughts he was ruminating on, such as concern about his lack of employment and subsequent finances to afford the activities he would like to be engaged in. Walking was a way Peter could process his thoughts because he enjoyed being outside and within the community where he was living. Peter said:

Oh, getting the fresh air and for fitness, yeah. It's always good to walk and think for me.

Peter (interview one)

As Peter's confidence grew the longer he was living in the community, he found he did not need to walk as he previously had because he was now familiar with how to carry out the range of activities he was involved in. He still used staff help when he needed

it; however, he found he was not ruminating as he had previously and was confident in his own skills.

Client participant Jae spoke of going to the local gym, which had a swimming pool, and how he used the hot pools as a place where he could relax. Jae's programme was often busy and he found having time just to relax was important for him to manage his transition. Jae stated:

I find the [gym] helpful, because you go down there and you can sit in the hot pool and you can enjoy being in the peace and quiet, keeping warm. I found that helpful, very relaxing, going to [gym] and going to the hot pools.

Jae (interview one)

Jae had found this activity during his transition out of the hospital ward. Originally, Jae had been encouraged to use the gym as a way of increasing his exercise; however, this particular gym also had a swimming pool and hot pool attached to it so when he went to the gym this is what he now did.

Surviving the setbacks was also an important part of a successful transition for clients. Surviving required the client transitioning to draw on a range of capabilities, including coping strategies and problem-solving abilities, to allow them to endure the setbacks that occurred. One of the most common setbacks the client participants spoke of was regarding employment and specifically the lack of employment for many of them. Wanting to be financially secure was understandably a focus for many. Client participant Peter spoke of his frustration of not being able to secure reliable stable employment. He knew employment was an important component to keeping himself well so he spent time upskilling to offer employers something extra. Peter had successfully obtained his full driver's licence, forklift licence and a range of other qualifications from the local polytechnic in the hope this would make him more attractive to potential employers. Though not yet obtaining secure employment was a setback, Peter managed it by remaining optimistic about eventually securing employment and continuing to focus on upskilling himself as a way of making himself more attractive to employers. Peter outlined the different qualifications he had completed:

Well now I've got level 2 painting and decorating and level 3 welding, umm, level 2 and 3 plumbing, gas fitting and drain laying and my forklift licence and I'm going to be learning a new trade with the plasterboarding.

Peter (interview three)

For Peter, surviving the setback of a lack of employment was to remain focused on what he could offer potential employers and to continually upskill himself.

For client participant Joe surviving was about making sure he was engaged in activities that did not create stress and anxiety he was unable to manage and helped work towards goals he had for himself. Maintaining regular exercise was important to Joe as he believed it was important for his physical health due to the medication he took meant he easily put on weight.

I've got an exercycle, and I go for a walk, try to go every day for a walk.

Joe (interview three)

Joe explained further it was important to him to have time when was also not engaged in activities. He both enjoyed and needed to have time to sit on his couch and enjoy doing nothing, though he was aware that he could become bored if he did was not engaged in some type of activity over the day.

Surviving the transition process required the clients transitioning to participate in a range of activities and engage in coping strategies which were about looking after themselves. Being kind to themselves and knowing what they needed to do to ensure they stayed well and remained on the road to recovery, was important for the success of their transition. What each client did to look after themselves to ensure their survival was unique to them. Getting through the transition for each person was an individual process. The time taken to move full-time to the community did not necessarily equate to the time it would take to fully adapt to living in the community again.

This chapter focused on the individual's experience of transition. Clients strived to regain their autonomy, though the environments in which they belonged were often non-autonomous. Transition did not finish for clients once they had moved to the community. Each of the client participants in the study articulated their experience of transition and each person still regarded themselves as still being in transition.

Successfully integrating into the community was dependent on several factors, all of which were dependent on their wellness, how they viewed themselves, and finding acceptance from the community.

The transition process, for the clients moving from hospital ward to the community within a forensic psychiatric service, looked very different on the surface. There were differences in the programmes individuals engaged in when moving to the community, the legislation individuals were governed by was not uniform, what each individual wanted to focus on while in the community was unique to them, how they incorporated change into their lives was approached differently and what they did to look after themselves was individualised. Staff participants reported a range of different reactions from their clients when moving back into the community. Clients had wide-ranging ways of approaching living in the community again, including taking their time to re-integrate, needing employment for well-being, not wanting the pressure of employment, and the support they required was individualised to their own needs. Superficially, it could be argued that the transition process to the community was so individualised that attempting to develop a framework or theory that provided insights into the meaning within the transition process would be impossible. Nonetheless, I believe this research project did highlight commonalities within the transition process for those moving from the hospital ward to the community within a regional forensic psychiatric service, and the next chapter details the meaning of these findings.

9 BEING WELL, BECOMING AN EX, BELONGING IN THE COMMUNITY

This study originated from my previous work history within forensic psychiatric services and my interest in how individuals adapt during times of significant change. Moving to the community after spending many years within the confines of hospital, where everyday activities like choosing when to eat meals and deciding when to visit friends are controlled and monitored, can prove demanding for both the client making the move and the staff supporting them. Concern for public safety is often pivotal for staff working within forensic psychiatric services (Blackburn, 2004; Kaliski, 1997; Robertson et al., 2011; Traverso et al., 2000), so transitions to the community are required to ensure the safety of the public, along with the encouragement of personal recovery for the individual client.

The purpose of this study was to explore how clients transition from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand. The factors that influenced the transition experience and what a successful transition looked like were also of interest. The findings of this study revealed that re-entering the community was both a navigation and negotiation process which required nurturing, and that the individual needed to be central to decisions being made by them and about them. The Apparatus of Transition (chapter seven) outlined components necessary for successful transition, Everyone's an Individual and Working in Collaboration. It explored the various mechanisms and structures that were in place to ensure power and control was exerted over individuals, including being Governed by Rules and Regulations, External Pressures and Managing Systems Capacity. It also told the story of the various ways staff attempted to reduce the impact of the apparatus for individuals, which then increased the likelihood of success for those who underwent this particular transition, such as Providing Opportunities and Creating a Safe Haven.

Regaining Autonomy in a Non-Autonomous Environment (chapter eight) told the story of the journey individuals underwent in their attempt to regain power and control over their lives, as they attempted to regain a life worth living in the community. The story was in four parts, Building Self-Determination, Inner Thinking: A Reason for Being,

Outer Thinking: Looking Towards the Future and Getting Through It. This chapter is primarily about making sense of the data and presenting what I believe they mean.

Being mindful of George's (1993) claim that transitions are too heterogeneous and reliant on the social context for a single, generic framework to be used to explain how an individual adapts to change, I recognised that none of the six generic frameworks reviewed in Frameworks of Transition (chapter three) could be used in their entirety for this project. Some of those transition frameworks did provide insights which were useful when considering forensic psychiatric transitions. For example, Selder's Life Transition Framework (Selder, 1989) recognised the meanings that individuals attach to their reality are altered during times of transition. Schlossberg's Transition Framework (Schlossberg, 1981, 1984) worked through ways professionals are able to support people in transition. Bridges' Three-Phase Framework of Transition (Bridges, 1986, 2003) also recognised that transitions impact on a person's way of being; however, the focus of this framework seemed to be more useful for transitions which were not desired. Finally, French and Dalahaye's Four-Phase Framework of Transition (French & Delahaye, 1996) recognised the skills and capabilities of individuals influenced success along with a person's desire for decision-making in the process. However, none of these frameworks had been developed with a forensic psychiatric context in mind. No unique features of a forensic psychiatric service were included, such as the impact of legislation which governs the process of moving to the community, the challenges of the link between mental illness and offending for forensic psychiatric clients, nor the type of transition being explored within this study.

Additionally, the forensic psychiatric frameworks reviewed, in chapter three, focused on what clinical staff could do to successfully move clients from hospital to the community and they provided guidance for staff on how to do this. None of those reviewed adequately provided insight into how forensic psychiatric clients adapt to living in the community again. Therefore, the extant literature did not provide insights into how those individuals within forensic psychiatric services adapt to living in the community. The theoretical framework, constructed over the course of this study, *Being Well, Becoming an Ex, Belonging in the Community*, contributes to filling the gaps identified at the completion of the literature review by providing an insight into the transition process of clients who are re-entering the community. This theory, which has been presented as a theoretical framework, has been constructed between the participants

and myself, and fits with Charmaz's (2014) belief that the theory "depends on the researcher's view; it does not and cannot stand outside of it" (p. 239).

MAKING SENSE OF THE DATA

Client participants Sebastian, Peter, Joe, Harry and Smelly all spoke of the range of activities that they engaged in that could be linked to keeping themselves well. These activities reinforced the self-identities and roles that they hoped would prove they were no longer dangerous individuals. The activities positively connected them to the community in which they were living. Client participant Jae, owing to losing access to his specialist funding, was unable to engage in the range of activities he required to keep himself well, unable to reinforce new roles and identity and, therefore, connect him to the community in which he lived. As a result, the success of Jae's transition to the community was compromised and he was struggling to make that transition.

The data suggests clients adapt to living in the community by Being Well. Each individual determined how that looked for themselves but it incorporated engaging in a life worth living as was determined by them. Being Well enabled the person to work on Becoming an Ex. That is, the individual re-evaluated how they saw themselves and made decisions on whom they wanted to be in their future. Becoming an Ex involved changing the roles they may have seen as being a barrier to their ultimate reintegration to the community, such as being a beneficiary, drug taker or forensic psychiatric client. By Being Well and Becoming an Ex this then enabled the individual to experience a sense of potentially Belonging in the Community. Each of these three areas was facilitated by the activities an individual was engaged in.

The theoretical framework presented Being Well, Becoming an Ex, Belonging in the Community. This framework provides insights into how clients within a forensic psychiatric service, transition to the community. Charmaz (2014) argues a theoretical framework should provide an anchor to the research. It should demonstrate how the research "refines, extends, challenges or supersedes extant concepts" (p. 310). Anfara Jr and Mertz (2015) believe a theoretical framework is related to the methodology being used and they define a theoretical framework as any empirical or quasi-empirical theory providing insights into psychological or social processes. They also argue a theoretical framework allows the researcher to present their understanding of the phenomenon being studied; however, no theoretical framework can provide a perfect

explanation. Within grounded theory research the use of a theoretical framework locates the argument the researcher is wanting to make. This theoretical framework offers a unique perspective to forensic psychiatric transitions to the community. The framework has arisen from the analysis and will prove useful to professionals working with the forensic psychiatric service. This belief fits with the pragmatist roots of constructivist grounded theory of making a practical difference by completing the research (Bryant, 2009; Charmaz, 2014).

Kidd (1973) asserted that the relationship between the three dimensions of Being, Becoming, and Belonging is dynamic and involves self-discovery, fulfilment, and self-expression. The relationship involves living a life that includes others, and is growing and developing. These dynamic factors can be seen within the framework being proposed as well, that of Being Well, Becoming an Ex, Belonging in the Community relationship. The dynamic nature of the relationship influences each of the dimensions. Maintaining wellness, developing new identities or changing roles and connecting to the community does not just happen, it takes focused and concerted work by individuals, it calls for an individual to make conscious choices about their future, to look at whom they would like to be and to engage with others for the success of the transition.

Wilcock (1998) claimed the link between Doing, Being, and Becoming was central to healthy living can also be seen within this research project. What the individuals were engaged in doing, as part of their transition to the community, had a direct impact on their wellness and on their Becoming an Ex. Wilcock (1998) did not originally include belonging in this relationship; however, I have. Doing is an important part of connecting to the community: individuals transitioning were all involved in a range of activities which helped to build connections within the community, which in turn, built a sense of belonging for individuals.

Yazdani and Bonsaksen's (2017) belief that congruence between what a person is Doing and the dimensions of Being, Becoming and Belonging was necessary for an individual to experience satisfaction with their life also has connections to this research project. I have claimed the three dimensions within my framework are interrelated and a focus on what individuals are engaged in doing, one that meets the needs of all dimensions, should be a priority.

The three core dimensions of Being Well, Becoming an Ex, Belonging in the Community can be achieved by focusing on what the individual is engaged in doing. The three dimensions of being, becoming and belonging are interrelated and linked by what an individual does. The success of the transition to the community is dependent on ensuring the focus of what the individuals are engaged in has balance over all three dimensions and is not skewed or focused towards a specific one.

The framework presented here is seen as a whole and then each of the three core dimensions is explored in detail. A visual representation of the framework is presented (figure 4).

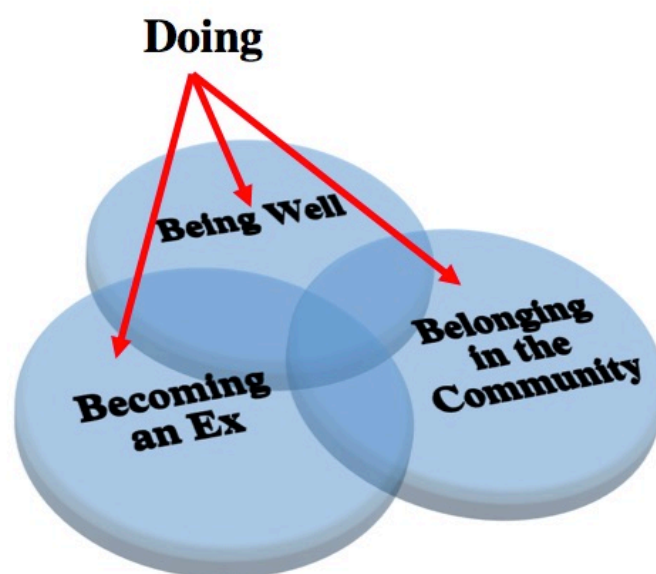


Figure 4: Being Well, Becoming an Ex, Belonging in the Community Framework

The three dimensions are not seen to be a linear process. The framework is not a checklist where individuals move through each dimension as if they were stages with Belonging in the Community being the final destination. Having said that, each individual wanted to Belong in the Community by the end of the transition process.

Each dimension of this framework impacted on the other dimensions, Being Well was important to Belonging in the Community and Belonging in the Community impacted on Becoming an Ex. Difficulty experienced in any of these dimensions impacted on the others. The area where each of the dimension's overlap represents the Doing aspect of the framework.

Where all three dimensions overlap, this area represents the Doing that enables the development of all three dimensions. For example, for both Sebastian and Peter employment was an important activity for these men. Being engaged in employment was shown within chapter three to be important for clients within mental health services and correctional services reintegrating to the community. Work helped them with Being Well, it provided stability, focus and a reason for getting up in the morning. Work provided many opportunities for them to develop their skills, confidence and capabilities, allowing them to focus on the present rather than ruminating on their past. Employment also helped them to experience Becoming an Ex. Holding a worker role was a move away from being a beneficiary, showing others that they were able to contribute to the community and to look after themselves. They were taking an active role in the community which meant they were moving away from being a patient. Both Sebastian and Peter wanted, in the long term, to become ex-forensic psychiatric clients. Employment also enabled Belonging in the Community. By connecting to the work environment, they were connecting to the people within that environment. Sebastian spoke of the trust his boss had in him and the responsibility he took from that. A sense of belonging was important as it enabled them to feel as though they had meaning in their life.

The next sections focus on each of the three dimensions and explore how the Doing element influences each dimension. Each section will begin by outlining how each dimension is understood within the thesis, and this will provide an understanding of the context of how the terms will be used throughout the remainder of the chapter.

BEING WELL

Being Well has been determined to be an amalgamation of the concepts of recovery, resilience, and well-being which have been explored in chapter 3 of this thesis. Recovery referred to individuals living lives which they have determined as satisfying and incorporated the hopes and dreams they have for their future. Resilience is the capacity to adapt when undergoing adversity, which then allows individuals to participate in their worlds as they desire. Well-being incorporates all aspects of a person, including physical, mental and social, these working together to enable a person to live a life they deem as good. To enable clients to achieve Being Well they were required to draw on a range of internal and external features central to transitions which

were discussed in chapter two. These include self-determination, self-efficacy, coping strategies, agency, meaning-making, self-identity and support. These features, working together, were fostered and developed over the course of each client's transition to the community and facilitated Being Well.

It was essential that individuals transitioning had the ability to make choices about what they needed or wanted to engage in that promoted their achievement of Being Well. Individuals required support from staff with decision making, rather than wanting staff to act paternalistically. By being actively involved in making decisions about their future, clients recovery was supported and this in turn promoted Being Well. All the client participants spoke about the range of activities they were engaged in that contributed to them Being Well. Harry recognised spending time with his own thoughts was important for his wellness, also, living in the moment was as important to him as looking towards the future. Peter spoke of his need to connect to his friends and to be socially active, along with needing to have the stability of work. Peter also recognised work was a stabilising factor for him and if he was not busy then he had the potential to become unwell. Joe, however, needed time not to be busy, though he did believe there was a fine line between relaxing and becoming bored, which was not good for him. He also knew the pressure of work at this stage of his recovery was not good for keeping him Being Well; however, walking, using his home gym and exercise were all important to him. Having the time and space to work on his computer programme was important for Smelly, along with not being expected to engage in a range of programmes other clients were involved with. Completing everyday activities, such as meal planning, cooking and household management were not important for Smelly Being Well. However, Sebastian recognised he needed to be able to look after himself; he needed to be able to complete his flat upkeep so he used the support of the staff at the forensic NGO as he built his capabilities and skills. All five of these client participants articulated a variety of activities they were engaged in that contributed to them Being Well. All were different and personal to them, and what was central was they could recognise the importance of these activities. These client participants were engaging in activities that were important to Being Well; they were developing skills and capabilities that they had deemed important for sustained community living.

The examples above show links to Deci and Ryan's (2000) work regarding the three psychological needs individuals have for health and well-being, those of autonomy, competence and relatedness, as outlined earlier in chapter four of the thesis. *Autonomy* and being central to decision-making in their transition to the community was viewed as important for clients. Choosing to engage in opportunities, taking control of their voice and using strategies they had developed to get through the transition waiting process were all seen as being important when exerting their autonomy. Experiencing *competency* and mastery set up the client for success in their transition and facilitated Being Well. Factoring for success and building capabilities enabled the clients to look towards their future and know they had the skills they needed to be successful and keep them Being Well. *Relatedness* and experiencing a sense of belonging enabled the clients to see a reason for being. All three psychological needs were important for the dimension of Being Well.

The clients' active engagement in a range of activities demonstrate how Being Well and Doing are intrinsically linked as they are in constant interaction. Being Well is dynamically connected to what individuals do which keeps themselves well, and is supported by Wilcock's (1998) claim of the inextricable relationship between doing well and well-being. Connections can be made to Wilcock and Hocking's (2015) assertions that health and wellbeing is linked to ensuring the activities individuals participate in provide satisfaction, hold purpose and meaning, provide the right amount of challenge, and importantly, involve personal choice.

Jae had a different experience: when he lost access to the unique forensic NGO funding stream, the impact on his Being Well was noticeable. As he could no longer afford to participate in former activities, staff reported a deterioration in Jae's wellness. It was the activities and his participation in them that was keeping him Being Well while living in the community. Jae struggled to understand why he was now required to fund his activities and this in turn impacted on him Being Well.

Being Well is the central dimension to the achievement of the other two dimensions, Becoming an Ex and Belonging in the Community: this is why it is seen at the top of framework. If individuals are not Being Well then it is very difficult for them to establish themselves within the other two dimensions. Jae's experience confirms this: his wellness was compromised and he was struggling to disengage with old identities and being accepted as part of the community. Sadly, Jae began engaging with both

drugs and alcohol during his transition. The staff participants reported the timing of these activities occurred after his change in funding stream, when the activities he usually engaged in, which helped him with Being Well, were no longer funded. He had difficulty understanding why this had occurred as he remained living in his flat and nothing had changed for him outwardly and he could not afford to pay for these activities himself. This type of behaviour is explained by Boyanowsky (1984) who argued that individuals who feel overwhelmed by their transition may engage in socially dysfunctional practices, such as illicit drug taking, as a way of coping.

BECOMING AN EX

Becoming an Ex incorporated the process of changing from a former identity, through role transition, which, as explained by Allen and van de Vliert (1984), is when an individual goes through a process of moving from one set of roles to another. Ebaugh (1988) stated the process of Becoming an Ex involves distancing oneself from roles previously held and moving into roles which fit with current, or strived for, new identities. Role transition is an important component of the Becoming an Ex dimension because, according to Allen and van de Vliert (1984), behaviour and self-identity are significantly influenced by it.

Becoming an Ex was an important part of transitioning to the community and incorporated multiple roles for the majority of the individuals who made this transition. For many, this included Becoming an Ex-patient, an Ex-prisoner, an Ex-drug taker, an Ex-beneficiary and an Ex-offender; what “Ex” each individual wanted to become was individualised. For all of those making the transition, however, the most important role exit they wanted to make was that of an Ex-forensic psychiatric client. The client participants reported this was one of the most significant identities they would like to change and the staff participants reported it was one they were likely to hear the most from the clients they supported in the community. It was this label that influenced their ability to access housing, access some of the activity groups they wanted to be involved in, and often their ability to obtain employment.

Individuals transitioning from forensic psychiatric services had many challenges to overcome in relation to role exit. Peter had wanted to move out of the patient role and into a worker role so had continued to upskill himself in a variety of areas for employment. He continued to experience difficulty securing regular paid employment.

Staff participants reinforced seeing this challenge: Sam had reported clients were encouraged to disclose to perspective employers and because of this, clients had found many challenges to the securing of regular paid employment. At times, finding appropriate accommodation had proved difficult. Both client and staff participants advised the label of forensic psychiatric client often eliminated those clients from certain accommodation, even when providers were within the specialist mental health services. Sebastian spoke about the label of being a Special Patient within the forensic psychiatric service and the double stigma he had to endure, being a Special Patient and a forensic psychiatric client. Ensuring these challenges were overcome successfully was an aspect staff focused on. Providing opportunities to build capabilities and increase individuals sense of confidence in their ability enabled the individuals transitioning to keep focused on their hopes for a future they wanted. Knowing they were capable of completing the endeavours they wanted helped to keep them focused on working towards the new identities they saw for themselves. Staff also provided support, such as accompanying clients to appointments with WINZ or offering standby assistance for flat maintenance, as a way of ensuring the clients did not revert to old ways of doing and being, such as expressing their frustration with violence or using illicit drugs or alcohol to combat their anxiety. The use of support is reinforced by Turner (2001) who states individuals in transition need external support by others to avoid the yo-yo effect and to ensure the changes made by the person will be long lasting. Sanders (2007) contends that hooks of change, such as appropriate relationships, opportunities for employment, treatment for drug use and having access to appropriate housing are crucial for sustained role transition. The attempts to negate the effects of the Apparatus by the staff participants, such as providing opportunities and helping to create a safe haven, can be viewed as attempts to engage individuals in hooks of change to sustain their role transition.

Peter and Joe spoke at length about how they were distancing themselves from the patient role. Though they were expected to spend one night a week in hospital, they were very clear this was not a role they saw themselves in any longer and they were keen to distance themselves from it. These actions fit with Goffman's (1961b) view that when an individual sees certain roles as being peripheral to their sense of self they will ensure they distance themselves from that role. Peter spoke of how he no longer saw himself as someone who needed to be in hospital. Returning to the hospital ward

was something both Joe and Peter did because they had to, it was a rule they had to follow, and if they did so without issue then the likelihood of one day not having to return to hospital one night a week would occur. Not seeing themselves as a patient, though they were returning to the ward one night a week, is supported by Allen and van de Vliert (1984) who state not all roles individuals engage in are central to an individual's concept of self. Those that are central to an individual's self-perception will be harder to abandon, while those that sit on the periphery can be disregarded with little distress or sense of loss.

Boyanowsky (1984) asserts physical separation from former reference groups is required to ensure self-identity change is facilitated and maintained. For clients transitioning who would like to become Ex-drug users and/or Ex-prisoners, it was important for them to ensure they did not spend time with those still actively engaged in these roles. Peter spoke of choosing to distance himself from previous acquaintances for this very reason. However, Boyanowsky (1984) also claims spending time away from the former reference group is not sufficient by itself to produce an identity change. Often the individual may feel in limbo during this time and the anxiety experienced by those transitioning may result in them clinging to a self-identity that is familiar and comfortable, their old one. This was seen within Jae's transition: owing to his increasing anxiety and distress of not understanding why he was now required to pay for activities that were previously paid for him, he returned to a familiar role and identity and began engaging in activities associated with it, such as, drug taking and alcohol consumption.

As discussed in the literature review, transitions to the community within forensic psychiatric service are often hidden, both by staff and the individual who is transitioning, and this can be seen as understandable when acceptance into the community is challenged. The staff participants of the forensic NGO advised they did not believe the members of the public in the vicinity to the complex actually knew what the facility was about. Pat advised that service people coming to complete work within the buildings would often ask what "the place" was about. Responses were kept general in an attempt to minimise the stigma that could be experienced by the clients living within the forensic NGO. Similarly, as already outlined, Sam believed a reason a number of clients who were transitioning to the community had difficulty securing regular employment was owing to their disclosure about their mental illness and their

forensic psychiatric label. These experiences are supported by Turner (2001) who argues the community itself can also pose many challenges to the alteration of previous self-identities. Attempting to move away from roles which are viewed as deviant and to cement roles associated with new self-identities can prove difficult. Those individuals who have been deemed distrustful by the community may have difficulty because they find themselves met with social avoidance or are ostracised and a punitive response is taken by the community.

Legislation was a common factor which had either impacted or continued to impact on the transitions for those moving to the community. Until the 'right' authority has been gained those making the move are expected to stay where they were, and this made it difficult for individuals to exit from the patient role. Legislation also labelled many of the clients who were transitioning to the community. Being known as a Special Patient made it very difficult to exit from the forensic psychiatric patient role and as stated earlier, the overwhelming role clients within the forensic psychiatric service wanted to exit from was that of the forensic psychiatric patient. This did not happen easily and it took years, if not decades. Sanders (2007) contends the political, cultural and legal factors all have the potential to impact on an individual's ability to successfully transition to Becoming an Ex.

The client participants spoke of the range of activities they were involved in which helped to prove to the people in authority and members of the public they were ready to exit the role of forensic client. Completing education programmes, keeping their flats clean and tidy, joining community groups, holding down employment, managing budgets and interacting appropriately with others were all examples of what individuals making this transition did in an attempt to Become an Ex. Therefore, from this project, the process of Becoming an Ex was facilitated by what each individual was Doing. Engaging in a range of activities which reinforced the new roles that were associated with the new identities each individual was striving for helped cement the Becoming an Ex process, thus, Becoming an Ex was intrinsically linked to Doing.

BELONGING IN THE COMMUNITY

Having a sense of fitting within their community, being accepted by others, being a valuable member of the community, were the goals the clients strived for as they transitioned to the community. The work they did in Being Well and engaging in the

range of activities that promoted Becoming an Ex, was to enable them to feel as though they were Belonging in their Community. The community then became a safe haven for the clients transitioning. These feelings of belonging had a positive impact on Being Well and this is supported in the literature. Ross (2002) explains a sense of belonging to the community is linked to self-perceived positive health statuses, whereas, stigma has the opposite effect. Rogers and Pilgrim (2003) advise us that social rejection, an experience often had by those within forensic psychiatric services, can have a negative effect on an individual's health status, which this fits with the Social Model of Disability (Oliver, 1990). While hooks (2008) believes experiencing a sense of belonging is seen as an important element to leading a life which is meaningful, has purpose and is worth living.

Mahar and colleagues' (2013) five core elements to the conceptualisation of belonging are useful when thinking about how belonging may be developed for forensic psychiatric clients re-entering the community. First, a sense of belonging is subjective and unique to each person. It is based on feelings of being valued, being respected and actively engaged in the community they want to belong to. Sebastian spoke of feeling respected and valued within his work environment and by his employer. He was able to complete his job in the manner expected and he believed he had much to contribute to his employment and this was important to his feelings of belonging.

Second, belonging is grounded to a reference group rather than the global "community". The wider community is a very big place and attempting to talk about belonging to the community as a whole was not useful for those transitioning. There were a number of different groups each person belonged to within the larger community, work environments, living environments, community groups, churches, family and friend networks, and others. Each of the client participants spoke of a range of groups to which they had connections and why belonging to them was important in their transition. Staff participants spoke especially of the importance of family as a reference group.

Third, reciprocity is also an important aspect of belonging. Connectedness and a sense of relatedness is shared between the individual and the external referent that person would like to belong. The connectedness is based on shared feelings, experiences and understandings. Shared feelings and connectedness could be seen within the narratives of the participants. Peter spoke of helping friends as being important because they had

helped him in the past. Harry and Joe both spoke of wanting to be there for family and specifically parents because they had been supported by them in the past. Smelly advised his connections with his parents kept him connected with his wider family.

Fourth, a dynamic interplay is present between the enablers and barriers to developing a sense of belonging. An individual's physical and social environment both contributes and detracts from the person's ability to belong. An example of this can be seen within Peter's and Joe's narratives. Both wanted to belong in the community; however, being required to return to the hospital one night a week meant they could not yet feel as though they were truly in the community.

Fifth, belonging requires an individual to make a choice on whether they want to belong or not. Self-determination and the ability to make an autonomous decision about belonging is crucial to developing a sense of belonging. This could also be seen within the research. Individuals transitioning were developing their self-determination during this process. They were in the process of developing their future identities, and used their voice to make decisions regarding the groups they want to belong to.

Taylor spoke of walking with a client around the local environment where they lived to enable them to become familiar with it. They visited cafés, walked through the gardens, located the closest bus stop and visited other local shops as a way of aiding the client to feel comfortable in that space. This technique is supported by Power (2013) who states experiencing belonging does not just happen merely because an individual is placed within an environment, but rather when they see they fit within that environment. Taylor was attempting to facilitate connections between the client and the place where they now were going to live, not just the building which housed their material goods but the wider community in which they would live. Antonsich (2010) claims the first part of exploring belonging starts by attempting to understand how an individual connects emotionally to a particular place and how they generate place-belongingness. Belonging is about finding a place where an individual can feel at home. Home is not a domesticated space in this instance (Antonsich, 2010; Dixon & Durrheim, 2004) but rather a space that is familiar, secure, comfortable and has an emotional attachment (hooks, 2008) and Taylor's work with the client was about facilitating this emotional attachment.

For many of the client participants the place they spoke of belonging was within the forensic NGO, and feeling connected, feeling safe and being trusted were highlighted. This was a place the client participants could belong. Peter spoke of his concern when it was his time to move from this place into his own flat in the wider community. He had some reservations about becoming isolated and not connecting to others. This was not a reason for halting the move; however, he was aware of the potential negative impact for him. Staff participants spoke of clients returning to visit at the forensic NGO after they had moved on. They often still felt connected and coming back felt like coming home. This is initially similar to those who return to the open rehabilitation ward for one night a week. Sebastian spoke of enjoying returning as it felt familiar and comfortable to him. Sebastian had only recently started living six nights a week at the forensic NGO. Others, such as Peter and Joe, who had been living six nights a week at the forensic NGO for approximately 12 months, no longer felt as though they belonged at the open rehabilitation ward. This process had happened over time for both client participants. Employment environments, community organisations and activity groups were also areas those transitioning were required to navigate the dimension of Belonging to the Community. For successful transitions to occur, feeling accepted and knowing they were understood and safe was central and linked to the identity the individual either held for themselves or were striving towards. The importance of identity and feelings of security is supported by Savage and colleagues (2005) who believe belonging encompasses spatial attachment and social position. It is not just about a fixed community with secure boundaries, but rather fluid as places have the ability for identities to be formed.

Individuals transitioning to the community also connected to gyms, recreation centres, internet cafés, the local polytechnic and the botanical gardens. Clients were actively encouraged to engage in the range of activities that each of these resources held. From taking time to walk through the gardens, upskilling and building capabilities at education centres, to maintaining fitness and health, these opportunities for doing were helping in building a sense of belonging for the clients. Engaging in these activities often required the person to interact with others within the environment. Connecting with the other people within the organisations required a reciprocal approach and this is supported by Hall (2009) who believes social inclusion and belonging have reciprocal links that have the potential to impact positively or negatively on each other.

Engagement in activities and the maintaining of relationships that have reciprocity within them influences both feelings of social inclusion and a sense of belonging.

People were also an important component to building a sense of Belonging in the Community for individuals transitioning. For all the client participants, including Jae, having the support of the professionals in their life was key to belonging. It was the professionals who provided opportunities for the clients to engage with others and to build relationships. The staff clients spoke of the range of activity groups they would attempt to connect their clients with. Taylor spoke of needing to know the community well and the different resources in it to enable her to connect her clients with the most appropriate activity or organisation. She stated at times she was frustrated by the lack of community resources that were available, specifically, to forensic psychiatric clients. Jae, Smelly, Peter and Joe spoke of the importance of their friends in their life. Friends were people who understood them and they could have a laugh with. Peter spoke about his need to regularly visit his friends and Smelly advised his friends kept him connected to the outside world. These aspects of belonging are supported within the extant literature. Mezey and Eastman (2009) state making choices and having the confidence and self-esteem necessary to engage in the communities in which individuals live are necessary skills for successful social inclusion. Carpiano and Hystad (2011) advise social inclusion helps build social networks for individuals transitioning. Improving social networks leads to improving health outcomes. Increasing the number of people a person knows in their community improves the social capital of that person. Having an extensive network of friends can be thought of as a type of social capital; however, it can be seen as more than this. A community that offers opportunities for interactions with others by having well-developed resources such as libraries, recreation centres and parks can promote social capital (Ross, 2002). For clients within mental health services, social capital is simply knowing there are people in your neighbourhood who are familiar, who provide safety and are resources for them potentially in the future, that is, they are people they can go to for help and reassurance when needed. For this reason, looking at where a person will be living in terms of the physical and built location, access to amenities and transport is important for establishing a sense of Belonging in the Community (Carpiano & Hystad, 2011).

The politics of belonging, as discussed by Yuval-Davis (2011), refers to the construction of boundaries that may include or exclude individuals from belonging to

particular communities by those people who hold the power. Politics incorporates a power differential with the dominant group determining who will be joining “us” and who will be remaining “them”. Knowing the social cues of the group or place that an individual who wants to belong is critical for acceptance. There is an expectation often by those granting belonging of sameness, an expectation behaviour, attitudes and understandings being the same as the group or place – difference is not encouraged. Often there can be an expectation of assimilation of language, values and behaviour by the dominant group (Antonsich, 2010; Yuval-Davis, 2011). As already discussed in the thesis, transitions to the community are often hidden by both clients and staff within forensic psychiatric services as a way of protecting the process itself. This was seen within this research when staff participants advised that members of the public were unaware of the purpose of the buildings that housed the forensic NGO, or who the people within the building were. Keeping the transitions hidden can be seen as a way of trying to avoid the negative social responses by the community, by not letting members of the public know the clients were within the forensic psychiatric service meant the clients then did not have to endure the often extreme reactions to them being in the community. Clients within this project were encouraged to disclose to prospective employers their engagement within the forensic psychiatric service and queries were raised by staff participants as to whether this was a reason for the lack of securing employment. The impact of social exclusion is very real for forensic psychiatric clients.

Developing a sense of Belonging in the Community and being socially included was often fraught with difficulties and those difficulties were different for each person. There were substantial barriers for clients to achieve social inclusion. Behaviours deemed odd by society make it very difficult for some clients transitioning to be accepted by society. A lack of understanding and an expectation to conform to expected ways of behaving challenged acceptance. Even if the clients transitioning were able to engage in expected behaviours, distancing themselves from the ex-role was next to impossible at times and that then inhibited belonging. Croucher (2004) argues belonging is a process of negotiation. Feelings of belongingness are eroded when a person feels rejected by others in that place or group to which the individual wants to belong. Belonging involves two sides, one that wants to belong and the other who has the power to grant belonging, and this was seen within the project.

Hagerty and colleagues (1992) outlined the outcomes of developing a sense of belonging: these include full engagement cognitively, emotionally, socially, and physically in the community. Interactions will be meaningful for the individual and the individual will want to be involved in all aspects of the community or group they are involved in. The absence of belongingness leads to isolation, displacement, isolation and alienation (hooks, 2008). The client participants within this research project developed a sense of belonging to a range of groups over the course of their transition to the community. This was seen by the level of activity they were engaged in doing within their groups. They reported feelings of respect, and being valued and trusted by the other members of their groups. Staff participants reported similar experiences when working with clients transitioning to the community. A number of the staff participants discussed the ways they facilitated the development of belonging in their work with their clients. All participants believed belonging was an important part of a successful transition process. All participants were also able to discuss examples of when a sense of belonging was not present and the challenges that occurred as a result. Research completed by Gerber and colleagues (2003) found similar results. Their participants, within forensic psychiatric services, developed a sense of belonging to the community in which they lived. Though their participants spent much time in their own homes, they self-reported being happy with the number of social contacts they had. However, community integration was still found to be poor and the focus was to improve it as community integration is aligned to positive health outcomes.

This chapter has presented the sense I have made from the findings of this research project. Being Well, Becoming an Ex, Belonging in the Community is a theoretical framework which gives insights into the process clients undergo in an attempt to live an ordinary life in the community. The three dimensions to the framework are facilitated by what the individual is doing. The three dimensions are interrelated, which means a dimension is both dependent on the success of the other two dimensions and will influence the success of the other two dimensions. An individual should feel well integrated into the community if they are completing meaningful activities that aid in their wellness, help to facilitate and reinforce roles and self-identities the individual is working towards and which connect them to their community.

The final chapter concludes this thesis by presenting my recommendations and implications for practice using the framework above to structure these. Future

directions for research are presented and I finish with offering my final reflections on both about my own transition journey and the forensic psychiatric transition investigated within this research.

10

CONCLUSION

This thesis has explored the client experience of moving from a forensic psychiatric hospital to the community. The thesis considered what factors influenced this experience of how clients engaged into the process of transition, and what a successful transition looked like. It has also asked: What was the process of transition for the clients in their return to an ordinary life?

The theoretical framework of Being Well, Becoming an Ex, Belonging in the Community provided insights into how those within forensic psychiatric services transition to the community. The three dimensions worked in combination to enable an individual to live a life worth living in the community to which they were returning. There were many factors which influenced the transition experience but the most significant was what each individual was doing during their transition.

When individuals were engaged in activities which focused on all three dimensions then their transition was supported. A successful transition to the community occurred when the individual was engaged in a life worth living, and completing a range of self-determined activities which facilitated each of the three dimensions. A successful transition also occurred when individuals were alongside the people they deemed important to them during this time.

This chapter concludes the research by outlining the recommendations and implications for practice, identifying the limitations of the study, making recommendations for future research, and reflecting on my understandings from my experience of this study.

RECOMMENDATIONS AND IMPLICATIONS FOR PRACTICE

The purpose of this study was to develop an understanding of the transition process; it was not to generalise the findings to the forensic psychiatric population. I do believe I have gained insights that may help ensure transitions are successful and these have provided the basis of the following recommendations and implications for practice.

Facilitating Being Well

Being Well is a holistic term that focuses on a person living a good life. As outlined in the discussion chapter, Being Well is an amalgamation of the concepts of recovery

(Anthony, 1993; Drennan & Alred, 2013), resilience (Rutter, 2012a, 2012b) and well-being (Deci & Ryan, 2000; Ryff & Singer, 2008) explored in chapter two. Within mental health services recovery is viewed as a personal experience, and what constitutes recovery is unique to the individual. The key aspect is that individuals will have a voice in determining what is important for them in their recovery. Wand (2015) argues organisations that adopt recovery principles provide services which promote empowerment, choice, collaboration and ensure the safety of the clients. Clients are assisted to regain control and personal responsibility, at the same time, reducing coercive practices. Organisations which incorporate recovery principles promote resilience by focusing on the capabilities, resources and abilities of their clients, and care is delivered in the spirit of partnership, respect and involvement (Simpson & Penney, 2011).

Incorporating the concept of recovery into forensic psychiatric practice is a recommendation; however, attempting to do so may pose many challenges (Mezey et al., 2010; Pouncey & Lukens, 2010). Simpson and Penney (2011) outline a number of those challenges, including the use of compulsory treatment orders, limits on liberty, the reduced ability by clients to be autonomous in the decision-making, and the requirement of treatment compliance. Overcoming these challenges is important for ensuring individuals achieve Being Well and the way this may be done is for staff to encourage the client to be an active participant in their transition and to help to facilitate their confidence in making decisions and choices.

Clients can defer to staff because this is familiar and for many, waiting to be told, allows the client to then distance themselves from making decisions. Taking a graded approach to encouraging clients to actively engage with the transition process and to work out what activities help them in their recovery is helpful. Looking towards the future and seeing the connections between what they are currently doing, and how it will contribute towards the future they want for themselves, may provide motivation to be involved. It is also important to allow clients to use their voice and to identify when activities they are involved in do not help with them Being Well; this will help to build trust with staff. In addition, clients may benefit from a variety of activities which allow them to build their skills and knowledge. Clients need to see these as being important for them.

Ensuring consistency appears to be crucial for clients during their transition. Making significant changes because of the needs of the service could potentially compromise the transition. Moving clients from a funding stream that pays for a range of activities to a different funding stream that no longer does, has the potential to negatively impact on the transition. This was seen within this project, and the confusion that arose appeared to have a negative impact on the client's Being Well. Changes to plans will, at times, need to happen during the transition; many of these may be about the progression of the client to the community. Consideration should be made about how these changes are communicated to both clients who will be affected and relevant staff from any organisations the client works with to ensure misinterpretations are minimised.

Facilitating Becoming an Ex

Becoming an Ex requires a client to re-evaluate whom they are and to determine whom they would like to be in the future. The roles taken by individuals are often representative of the identity an individual has of themselves. From the study, Becoming an Ex forensic psychiatric client was the most common identity that those transitioning wanted to achieve – it was also the most difficult. There were other identities those transitioning strived to change including, Becoming an Ex beneficiary, an Ex patient, an Ex drug taker and an Ex offender. Having opportunities to engage in a range of activities that support the new self-identities could be beneficial for those individuals transitioning. Having an awareness of community resources and opportunities by clinical staff and others involved with the care and treatment of clients potentially increases the opportunities for clients to be engaged in a range of activities that would help with their Becoming an Ex. Owing to extended time in hospital the community can seem like a huge mystery to some so having those who are supporting clients transitioning being able to offer opportunities is likely to increase success.

Becoming an Ex can be challenging when members of the public in the community are distrustful of clients. Creating a safe haven for individuals transitioning, both physically and emotionally, is likely to create an environment where individuals will take chances with self-determining their future, trying new things and becoming invested in where they are living. If the individual is engaging in behaviours which

members of the public will deem appropriate, then they are more likely to view them as well adjusted and no longer participating in the deviant role.

The prospect of Becoming an Ex ideally should begin when the client is still in hospital. The focus should start with identifying ways the client is able to see that the activities they are engaging in will help to facilitate their new self-identities. For some of the clients, it might be about initially exploring their offending history and seeing how past behaviours have reinforced identities they now want to change. Working in collaboration with the client, along with the important people in their lives, and focusing on the different behaviours needed to fit with the reconfigured perception they have of themselves may be beneficial. There is a need to encourage all of those involved to understand that this process takes time and that there may be challenges and changes of direction along the way. This may keep both the client and all those involved in supporting the transition motivated to see success.

Facilitating Belonging in the Community

Belonging in the Community is a process that has many facets. The community, as a whole, is where each of the individuals would like to be. Similarly, to the two dimensions already covered, work on facilitating a sense of belonging to the community should begin while in hospital. Encouraging clients to identify the range of communities that could be important to them during their transition and those communities with which they plan on continuing, when out of hospital, would be a good place to start. For example, experiencing a sense of belonging with the supported accommodation could be important for those who were moving there as their initial introduction to the community. For others, church groups, charity groups, and places of employment are all communities some individuals would want to continue to belong to long after they had moved back into the community. Spending time exploring the expected behaviours of the communities could be helpful for the individual to enable them to know what they should be doing to ensure they socialise appropriately.

Experiencing a sense of belonging has unique characteristics for each individual. Belonging is based on reciprocity so it may be useful to spend time with the individual transitioning looking at ways they can contribute to the community, alongside looking at what they can possibly expect from the community in which they would like to belong. Feelings of trust, respect and being valued have all been identified as important

components of experiencing a sense of belonging. Looking at ways where these aspects can be developed and nurtured may be a good starting point for those transitioning.

Self-determination and having a sense of choice as to whether individuals want to belong is one of the first aspects that should be established. At times clients will be directed to places where they might not initially want to be, such as being discharged to supported accommodation, and this has the potential to impact on a sense of belonging for the client. Initial work could be done with the client about the reasons why connecting with the step-down accommodation would be helpful to them. Working with the client to enable them to see what they want for their future is still very much part of the plans being made.

Connecting to a place, that is experiencing a sense of place-belonging, has the potential to facilitate real connections to others and the community as a whole. As described in chapter nine, place-belonging refers to a sense of home, not a domesticated space but rather a place that has an emotional attachment. A feeling of home can also refer to specific collectives and not just a physical space. Helping to facilitate a sense of place-belonging with those transitioning has the potential to help an individual to see a reason for their being, rather than just existing in a place. Encouraging connections to whānau/family, and relationships that are long lasting and stable, where each person cares about the other could help in the facilitation of belonging. A range of activities to facilitate belonging could be explored as active facilitation has been seen to be necessary (Mahar et al., 2013), rather than expecting belonging to be experienced just because a person is now in that place. The inclusion of culturally appropriate input from staffing who are experienced to provide it could be explored because cultural factors such as a common language has been shown to help facilitate belonging.

Facilitating Being Well, Becoming an Ex, Belonging in the Community

Being Well, Becoming an Ex, Belonging in the Community has been described in chapter nine as not a linear process. The process of transitioning and becoming integrated in the community is an individualised process that requires each person to determine what is needed for themselves. Each of the three dimensions is interrelated with the others, and success or challenges in each dimension has the potential to impact

positively or negatively on the others. What staff and other significant people can do to support this process is potentially substantial. Looking at the whole rather than the individual components could help with the success of the transition. There is potential for many of the activities the clients engage in to help build one of the dimensions could also be useful to help build other dimensions.

Keeping the needs of the client in transition as the primary focus would be useful. External pressures and managing system capacity have the potential to create barriers to a successful transition for individuals. Clients moved too quickly into the community or changed funding because of requirements of other clients has a strong possibility to impact negatively on an individual, so returning to an ordinary life could become difficult. Providing opportunities for success, creating safe havens, and ensuring factors for success have been included into transitions could collectively improve the likelihood of successful transitions to the community and sustain a life worth living.

Encouraging work, using the framework, while clients are still in hospital, could help them to understand why they are being encouraged to participate in certain activities. It could also encourage them to identify activities that are important to their own transition. For example, securing regular long-term employment and developing skills in budgeting might help reduce stress regarding rent payments and cover other necessary bills each week for some clients. Reducing stress and anxiety is likely to promote Being Well and stability in being in the community. Being able to ensure there is enough money for rent and paying other bills promotes roles associated with independence, community living and stability, thus, promoting Becoming an Ex-patient and an ex-beneficiary. Last, holding down employment enables an individual to find purpose in their world, to form and build relationships with others that are reciprocal and to see they have a stake in their future in the community, thus, Belonging in the Community.

For some of the clients, the focus of transition will not necessarily be on identifying and engaging in a whole range of new activities but rather, looking at what they are currently engaged in and making adaptations where necessary to ensure the facilitation of all three dimensions. An example from this research could be with Smelly, who was very focused on his computer programming work and had interests in this for the future, though some staff believed this was unrealistic. For Smelly, his computer work helped him with Being Well. Incorporating his computer work into activities could

further help him facilitate Becoming an Ex as well as Belonging in the Community. Potentially, there might be scope at his new accommodation in the community where he could engage with computers that gives back to the organisation. Smelly believed once he left hospital he should be finding work and if this was incorporated into where he was living, then Becoming an Ex-patient would be facilitated along with Belonging to his Community within the supported accommodation.

Being mindful of the whole theoretical framework would enable clients to engage in the activities that would nurture and facilitate the building of all three dimensions. To enhance the positives of the transition, it would also be important to engage all of those involved in the lives of the individuals undertaking transition. Clinical staff and the client themselves would be regarded as a given; however, including whānau/family, other professionals such as community support workers and any other person the client identifies as being important to them in this framework may provide useful information and feedback for the transition process.

Though the research was carried out following the research process outlined in chapter six, there were a number of limitations to this study which may have influenced the final outcome.

LIMITATIONS OF THE STUDY

All the client participants were male but this was not intentional. Both male and female were eligible for the research though no females took up the opportunity. The service in which the research was conducted provides treatment for both male and female clients; however, from my experience, males tend to dominate the client numbers so no female clients may have been available for inclusion at that time. The findings may have been different if females' voices had been included in the project and any future research ought to ensure they are incorporated.

The study included six client participants: five who completed three interviews each, and one who completed only the first interview. Originally, I had hoped to have included 10–15 client participants but this did not occur. Forensic psychiatric staff were used to identify and approach potential clients who would be appropriate to participate in the research and only after they asked for more information was I advised; this was the process the service wanted to follow. I did not hear back from a number of the clinical staff within the forensic psychiatric service, even after numerous

attempts to contact them, so I was unsure if potential clients had been approached and declined or if they had not heard about the research. For the future, alternative ways of ensuring clients hear about the research could be investigated to ensure a broader range of client participants are included.

Staff participant numbers were also lower than first expected, particularly of staff working within the forensic psychiatric service. Initially, I had hoped to include 10–15 staff participants from the forensic psychiatric service alone; however, this did not occur. There were several possible reasons for this. Many of the forensic psychiatric service staff knew me from my previous work history within the service. Potentially, some of the staff may not have wanted to participate because they may have felt uncomfortable speaking with me about some of their insights or thought I may have made judgements based on their responses. The research was carried out in a main city that had undergone a number of significant changes and as a result mental health services were stretched to capacity and staff were often involved in many activities outside work so this may have felt like something else to add to their workload and it was something they could decline. Workloads within District Health Boards and forensic NGOs can be considered high so many of the staff may not have felt as though they had the time to spend between one and two hours with me. Even though the senior management of both the forensic psychiatric service and the forensic NGO were supportive of the research and were happy for staff to complete their interviews during their work hours, taking time off from work may have created a higher workload later for the staff as they would have had to return to the work they should have completed during the time they gave for the interview. Looking at ways to ensure staff are able to join research if they desire to would be helpful in the future, including interviewing staff outside work time, employing a research assistant to complete data collection, and compensating staff for their contributions.

None of the client participants included in the research were initially living independently from hospital or the supported accommodation, though several of the client participants did increase their time in the community and this included two of the client participants moving out of the supported accommodation and into their own flats. Including the voices of clients who had transitioned directly from hospital to living in their own flats in the community would have been useful for the project. Including their voices may have provided insights into the transition process for those who did

not have the step-down accommodation option and this may have impacted on the subsequent framework that was developed. Looking at what activities those who move directly into the community engage in and how they develop a range of support systems would have added to the project.

The range of ethnicities identified by the client participants did not fit with the population of forensic psychiatric services. Generally, the Māori population of forensic psychiatric services is approximately 50%; however, within this project only one of the clients identified as Māori, which equates to 17% of the client participants. This is not representative of the forensic psychiatric services. Determining why those who identify as Māori did not engage with the research is multilayered. Initial discussions were held with the forensic psychiatric Māori health workers to discuss the research project in an attempt to ensure strategies were included which would encourage those clients who identify as Māori to want to participate; the strategies identified were incorporated into the research design. Support was gained from the Māori health service within the mental health division and staff advised they saw the benefit of the research and were encouraged by it. The inclusion of a Māori researcher into future projects may encourage those who identify as Māori to participate.

The research was conducted within one forensic psychiatric service only, therefore, the findings are relevant to this specific regional service. Had this research been completed over multiple sites and data gathered about a range of processes used to support those transitioning then the findings may have been different. It may be useful to replicate the research over multiple sites to ascertain whether the findings may have been different.

Not living in the same city as where the research was carried out was also a limitation of the study. I travelled almost 400 kilometres to the forensic psychiatric service to interview the clients therefore I was required to make arrangements to interview multiple participants during each visit. The research would have been enhanced had I been able to interview one participant, transcribed that interview, completed the initial analysis and then used that information to guide the next interviews I completed. This would have enhanced the research because each interview would have been more focused on what I believe was being highlighted.

Finally, my connection to the forensic psychiatric service had the potential to be a limitation of the study. I had insider knowledge of the service I was completing the research in, including knowing the staff and some of the clients. When interviewing those staff and clients who knew me there was the potential for me to have misinterpreted what they said, read into the meaning of their responses because of my prior knowledge. Because of our past relationship, potentially the participants may have attempted to ensure they gave me responses that they believed I wanted to hear. Our previous relationship may have encouraged participants, both clients and staff, to be more forthcoming; however, they may have altered how or what they said because of our past relationship. Having a researcher who did not have prior knowledge of participants could have ensured participants felt comfortable with disclosing information they did not want to disclose to someone they knew.

Despite these limitations to the study, I believe the research is useful in providing an insight into how those within forensic psychiatric services transition successfully to the community. These limitations form the basis of many of the research directions for the future.

FUTURE RESEARCH

Further studies looking at the transition process within forensic psychiatric services would help shed additional light on this complex process. Replicating the study in other regional forensic psychiatric services would provide insight to whether the framework was useful for a wider population within these services. Ensuring the inclusion of a broader range of client participants would be helpful to see if there were changes in the perceptions of those transitioning. Clients who have been living in the community for many years, clients who have moved directly to the community rather than using step-down accommodation, ensuring clients who identify with ethnic groups, who are predominantly within forensic psychiatric services, particularly Māori, would be helpful in ensuring a true representation of the process was explored.

Further exploration of the framework of Being Well, Becoming an Ex, Belonging in the Community should be conducted. From this study, these three dimensions have been found to be important for a successful transition, and additionally, what an individual is doing directly influences the establishment of these dimensions. It would be useful to explore these dimensions in greater detail and how engagement in Doing is connected.

Having a clearer understanding of how this framework influences the transition process within forensic psychiatric services would be useful for the long term.

Future research which explores the forensic psychiatric staff and client perceptions of this framework would also be helpful. Gaining insights into staff and clients understandings of the framework and how it might be linked to successful outcomes of transition would add more depth to the understandings of this process. Staff would be able to provide outsider insights into the process while clients would be able to provide insider insights into the process. Both viewpoints would provide valuable perspectives.

Exploring each dimension and its connection to doing in more detail would also be helpful. Exploring the aspects of doing and engagement in purposeful and meaningful activity and how it links to Being Well, Becoming an Ex and Belonging in the Community would provide greater knowledge about the transition process. Understanding the links between doing and the three dimensions would provide insights into not only what should be included in future transition planning for clients but also the focus of support for those living in the community.

Based on these findings, future research could focus on the development of, and then the assessment of, a transition programme that is based on ensuring clients are engaged in activities that are achieving Being Well, Becoming an Ex, and Belonging in the Community. A group of clients from within the forensic psychiatric service population who are moving towards community reintegration could be encouraged to be part of the project. The programme would include education for staff, clients and relevant others (including family/whānau and other organisations staff) about how the three dimensions work together. Actively involving the client in the decision-making about what they would like to be engaged in would be useful. By using this framework with more than just staff, a holistic focus would be encouraged that would look beyond symptom management and compliance with medication. Potentially, this could be started with a small pilot group and then rolled out with a larger population if proven to be successful.

Finally, exploration of the use of this framework with other populations may also be beneficial. A number of groups also experience many challenges to reintegrating into the community after periods of time out of the general population. Those clients who spend many years within general mental health services also experience difficulties

with transition, as do those who are returning to the community from the prison service. Exploring whether the framework would be useful within these populations is also research that could be completed in the future. Those within corrections and those within general mental health services experience many of the same challenges as those within forensic psychiatric populations. Therefore, a smaller pilot study may also be useful and if successful, rolling out a similar study with a larger population would be encouraged.

FINAL REFLECTIONS

I would like to return to my own understandings and preconceptions as I recognise these experiences have influenced how I view my world and they have also helped to influence the interpretations I have made of the data within this study. The knowledge that I hold and my understandings of my experiences, of the forensic psychiatric population and service and transitions, has led me to the conclusions I have made.

I can see the links to Being, Becoming and Belonging in my own recent experience of transition, moving from a PhD student to an academic. My transition would be titled, Being Focused, Becoming an Ex-student, Belonging in Academia. Being Focused was central to the other two components coming to fruition. Being Focused incorporated persistence and at times, dogged determination. If I hoped to become an Ex-student and Belonging in Academia, then I was required to remain focused on completing my PhD to the high standard required. It now will be others who determine whether I can Become an Ex-student to ultimately Belong in Academia.

Forensic Psychiatric Transitions

Transition is a complex, multilayered process. When looking at the process of transitioning to the community, what is actually happening is multiple transitions in unison. To successfully reintegrate into the community, then, an individual must look at whom they are, and whom they would like to become, along with being reflective on what keeps them Being Well. Finally, a sense of belonging is not something that will be experienced just because an individual is within a given environment, it requires active nurturing.

Transitions require individuals to use a range of personal factors which may or may not be already developed. Having the ability to adapt to changing environments, finding

meaning in given situations, knowing who they are, being able to determine their own future, being aware of their strengths and the areas that cause difficulties and, finally, a belief they have the ability to make choices and decisions that will influence the future they are in the process of making. All these factors are complex and are used in the process of Being Well, Becoming an Ex, Belonging in the Community.

From this study, five points have become clear to me through this process, points that may help support those negotiating the transition process to the community. First, transition is an individual and complex process: for the success of the transition the individual should always be the central focus. Second, active engagement in meaningful activities helps to centre a person and to enable them to see purpose and reason for being. Third, people matter, that is, individuals transitioning to the community need support and the people in their world are important in keeping them connected to their transition. Fourth, ensuring clients are listened to, that is really listened to, will help create the success of the transition. Last, if an individual perceives their disclosure will have a detrimental impact on their liberty then the individual will stop talking. Ensuring individuals have a safe haven to help them to disclose what they are thinking about, their beliefs, and their concerns, without the fear of having an automatic response that they perceive as negative, will enable them to use their voice more often.

Opening the door of the cage, that is the Apparatus, clients within forensic psychiatric services are desperately trying to get out of is only the starting point of helping to facilitate the transition process. Providing opportunities to build skills and confidence, incorporating what is needed for success, and creating a safe haven are all aspects that staff can help facilitate to encourage clients out of the cage. Attempting to get out of the cage can take time; it is a process an individual must get through as they build their self-determination to help direct where they want to go. Only once they are out of the cage will individuals truly see a reason for being because the future they are focusing on will have meaning. A successful transition to the community will provide benefits for many. The forensic psychiatric service and society will be secure in the knowledge the individuals living in the community are contributing, staying well and belonging. Most importantly, the individual will be living a life worth living, one they envision for themselves.

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APPENDICES:

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social researchUpdate

Walking Interviews

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- **The use of the walking interview is increasing within social research and is been used to explore the connection between self and place**
- **The walking interview takes various formats, but all entail the researcher accompanying a participant (usually on foot) around a given location while interviewing them**
- **Advantages of the walking interview include helping to reduce the power imbalance and encouraging spontaneous conversation because talking becomes easier with walking**
- **Practical and ethical considerations must be anticipated and accommodated to ensure the interview is safe for both the participant and the researcher**

Walking interviews are emerging as a distinct qualitative research method within the mobilities paradigm (Sheller and Urry 2006) and are increasingly being used to explore the link between self and place (Evans and Jones 2011). This *Update* outlines and focuses on four different formats of the walking interview, explaining how each format is used and what its purpose and focus is. It then examines the value of the walking interview as a data collection method for social researchers and outlines practical and ethical challenges when undertaking walking interviews.

What are walking interviews?

A walking interview is when the researcher walks alongside the participant during an interview in

a given location. Various formats of the walking interview have been described (Anderson 2004; Carpiano 2009; Clark and Emmel 2010; Kusenbach 2003). Each has a slightly different focus, purpose and aim, but they all involve the researcher talking with a participant while accompanying them, usually on foot, around a specific location. The walking interview is recorded and transcribed later. Cameras can also be used during the walk to capture data to be explored in subsequent face to face interviews.

Walking interviews can be seen as being on a continuum from researcher driven, that is, the researcher decides on the location and the route to be taken, to the walking interview being participant

Appendix A

driven, that is, the participant selects the location and the route for the interview (Evans and Jones 2011).

The docent method was developed by Chang (2017) during her research into the connection between place and health. Each participant is regarded as an expert guide, a docent, who escorts the researcher to and around specific areas in their lives that are significant to them. In the docent method the participant is the educator while the researcher is regarded as a novice, follower and learner. This method has three stages. The researcher initially meets the participant in a warm up interview which focuses on route planning and rapport building. The second stage is the walking interview around the specific place where photos can be taken to record what is seen and discussed, and finally a wind-down interview occurs and the photos are used to provide prompts for discussion.

The go-along walking interview is a mixture of an interview and participant observation. It occurs when the researcher accompanies the participant on an outing that would have normally occurred even if the researcher were not present. It is important the researcher accompanies the participant in their natural environment, while completing their usual routines at the normal time and day (Kusenbach 2003). During the outing the researcher asks questions, listens, and observes the participant while they go about their usual routines. The interview occurs in a similar fashion to the traditional sit down interview. Open ended questions are used and the researcher is prepared with a range of questions they want answered, although ad hoc questions may also arise as the interview progresses (Carpiano 2009).

Carpiano (2009) used the go-along interview to explore health issues within the local environment. He found it to be useful for exploring

the physical, mental and social dimensions of place over time for an individual. It provided insights into how an individual engages with their social and physical environment and how well they tolerate the demands of their usual activities.

In the participatory walking interview the route chosen by the participant to walk is not necessarily representative of a route the participant normally follows, nor does it represent the participants' usual routines or habits. The researcher accompanies the participant on a walk around a geographical location that the participant has selected which is related to the topic being investigated (Clark and Emmel 2010; Emmel and Clark 2009). The purpose of this format is to enable the researcher to access the participants' attitudes and knowledge about a specific geographical area (Evans and Jones 2011). It aims to provide insight into the sense of attachment a participant has with their neighbourhood.

Emmel and Clark (2009) developed a toolkit to enable researchers to use as guides when using the participatory walking interview which does not aim to provide prescriptive instructions but rather insights into what researchers should consider. What is key, is that participants make all the decisions, including the route to be followed, the length of time the walking interview will take and what they would like to show the researcher. The participant is in control of the interview; they are regarded as experts in their geographical area and act as tour guides.

The fourth walking interview format does not use the participant as a tour guide because the route and the geographical area that the walking interview occurs in is not important to the outcome. It is the process of walking and talking that is important.

Bimbling has been described as the

practice of going for a walk with no clear aim other than to blow off steam (Anderson 2004). Bimbling, within walking interviews, has been used to explore topics such as activism when it is important to take participants away from a highly politicised environment (Anderson 2004; Hein et al. 2008). This talking while walking interview is conducted in a similar fashion to the previous formats, however, the route taken is not necessarily known to either the participant or the researcher. It is the act of walking that allows the participant to recollect experiences and to articulate them (Anderson 2004; Moles 2008). Concern is not with the geographical location where the walking interview is occurring (Jones et al. 2008), rather the walking allows conversation to occur about a specific topic and allows talking to flow naturally because the pressure of a face to face interview has been removed.

Advantages of the walking interview

Walking interviews provide the researcher with opportunities to observe the participant in interactions with others in their community (Carpiano 2009). Walking interviews also provide insights into the relationships with others or the sense of alienation or loneliness that the participant experiences; such insights are less obvious in sit down interviews (Butler and Derrett 2014). In my research I found talking becomes easier when walking. Unnatural pauses that occur in a sedentary face to face interview can be replaced with natural occurrences on the walking interview. For example, when crossing the road or walking up a hill it would be expected that conversation would cease until those activities are completed, which gives time for the participant to ponder what they want to say next.

When wanting to explore the participants' understanding of place

the walking interview provides the researcher with an opportunity to observe and not just hear an account (Jones et al. 2008). Walking alongside a participant is regarded as an inclusive process compared with the traditional sit down interview because it is viewed more as a partnership, thus reducing power imbalances. It allows participants to feel more comfortable with the research because it is being conducted in a geographical location that they are familiar with (Trell and Van Hoven 2010). Because this method of interviewing allows the interviewer and participant to walk side by side rather than being situated directly opposite each other, the walking interview has the potential to benefit participants who are regarded as vulnerable, have a suspicion of or anxiety about those in authority or have difficulty with spontaneous verbal communication.

Although walking interviews are increasingly being used when exploring the connections between place and a person, they offer benefits to other studies also. Potentially, studies exploring the needs of people in regards to town planning, the links between identity and community, transitions and the community, and how place influences people's roles could all benefit from the use of walking interviews. Previous studies which have used walking interviews include undergraduate students' lived experience of higher education (Holton and Riley 2014); how social connectivity is maintained (Hodgson 2012); and inequitable walking conditions for the older person (Grant et al. 2010). Talking while walking was also used for researching mobile artists' work (Heddon and Turner 2010).

Practical and Ethical Considerations

The practical organisation of the walking interview and the ethical considerations that researchers must

be mindful of are intrinsically linked. A number of researchers (Butler and Derrett 2014; Carpiano 2009; Chang 2017; Clark and Emmel 2010; Jones et al. 2008; Moles 2008) have outlined the lessons they have learnt during the process of completing walking interviews. There are factors that are out of the control of the researcher but will significantly impact on the walking interview which require consideration. The weather is the most significant factor, driving rain, strong winds or icy conditions all have the potential to disrupt the walking interview. It is important for the researcher to make alternative plans, which may include changing the day or time of the interview, and if that is not practical, changing the mode of transport to using a car or a bus. Any alterations in the mode of transport will bring their own safety concerns. For example, as a sole researcher driving during heavy rain or icy conditions while trying to interview a participant raises safety concerns in itself. What is key, is that the researcher makes plans for these possible occurrences (Carpiano 2009).

The researcher will need to ensure they have assessed the physical capability of their participant for the walking interview and make any necessary adjustments. Walking in secluded areas, in or around people's homes, in or around bars or when the light is dim could be unsafe (Jones et al. 2008). Discussions on appropriate places and times to complete the walking interview needs to occur as early as possible.

How to record the walking interview is also a decision that the researcher needs to consider. From small hand held digital recorders with lapel microphones to large complex recorders, the researcher will need to determine which is best for their project. Whichever recording method is used it is likely that not all of the interview will be captured. Weather, traffic and other people talking can

all impact on the recording quality so researchers need to be mindful they may not hear all of the interview (Emmel and Clark 2009). Small hand held digital recorders with a lapel microphone should be used when the researcher would like the walking interview to be inconspicuous, or the researcher would like the participant to wear the lapel microphone and operate the digital recorder, or if there is concern the recorder may get wet as the smaller recorder is simpler to protect. Larger recorders, which have features for removing background sound, should be used if the audio quality is an important factor for the researcher.

The structure of the interview can be similar to that of a sedentary interview. Structured or semi-structured formats can be used, but carrying documents or a pen and paper may not be appropriate, so the researcher will need to consider how they will ensure they remember to cover the questions they want to focus on.

Ethically, confidentiality is to the forefront in walking interviews. Confidentiality cannot be assured if the walking interview is in a public place. Ensuring the participant knows they will be seen alongside the researcher is an important part of the informed consent process and should also be repeated prior to the walking interview commencing. It is also likely that members of the public may overhear the conversations occurring during the walking interview, so the participants need to be made mindful of this too. Discussions need to be held with the participant prior to the interview on what they would like to do if they bump into people they know (Emmel and Clark 2009). It is important this is planned before setting out so that confusion does not occur during the interview.

Conclusion

This *Update* has outlined the features of the walking interview,

Appendix A

focusing on four formats. The walking interview offers social researchers an opportunity to gain insights into their participants' connections to place and to their social environments within their neighbourhoods. Talking becomes easier when walking. The act of walking allows participants to recall memories and/or experiences they may not have in a sedentary face to face interview. The walking interview offers opportunities to vulnerable and marginalised populations to be included in research by reducing the power imbalance. The walking interview does have a number of practical and ethical considerations that must be addressed to ensure the safety of both the participant and the researcher, but these are manageable and can and should be addressed to ensure the voices of vulnerable and marginalised populations are included in the research. Literature on the use of walking interview and the mobility paradigm is growing and this *Update* provides a range of references to use as a starting point for researchers interested in incorporating walking interviews into their projects.

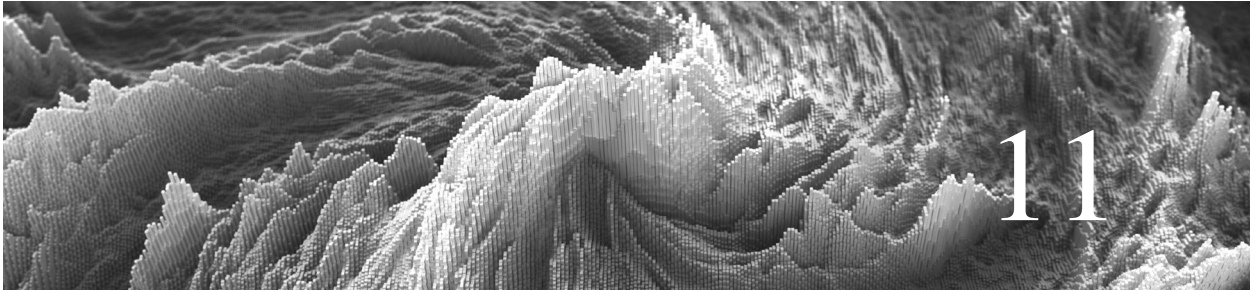
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Walking Interview Ethics

Penelope Kinney

INTRODUCTION

Two comments by Kathy Charmaz frame this chapter. The first came during a keynote presentation at a Qualitative Health Research Conference, 17–19 October 2016, in Kelowna, British Columbia, where she reminded me that as researchers our assumptions shape our standpoints and inform what we do. Necessarily, the methods used to collect data reflect our values. The second comment came more as a question during an informal gathering with others. She asked how the walking interview technique, documented in this chapter, gained ethics approval. The sense given during that discussion was that, in parts of the USA, Institutional Review Boards (IRBs) and, in Eastern Canada, Research Ethics Boards (REBs) take a conservative approach to what seems on the surface, to be a straightforward research method. The research discussed below focuses on forensic psychiatric clients' transitions from hospital to living in the community. The answer to the first comment is that this

research was based on an assumption that forensic psychiatric client voices need to be heard within this research and if that was to occur then data collection methods needed to be ones the forensic psychiatric client could engage with. The choice of using walking interviews was a value-based one. The transition the clients underwent is fraught with insecurity and the walking interview captures their uncertain steps.

The body of the chapter provides an account of the complex process undergone in gaining ethics review from my university ethics committee and simultaneously with the hospital where the research took place. An insider status bolstered gaining approval; previously I had six years' experience as a forensic psychiatric occupational therapist. The chapter begins with defining the walking interview, recognizing its strengths and its emergent status, and outlining three of the different formats I used in my research. The goal of transporting a client interviewee to another spatial location is one of its strengths;

photo elicitation by contrast, does the same in a static form and this comparison stresses the walking interview's power of mobility. The next section, on using the walking interview, includes examples of my research in the field. The chapter ends with discussing big ethical moments that emerged when transiting the interval between hospital and the community. One was the need for audience segregation when someone known to the client interviewee unexpectedly met us; this meant having to make decisions on whether to explain what we were doing and managing spatial breaches of confidentiality when the forensic psychiatric client interviewee discusses intimate experiences in crowded spaces. Whilst these and other moments were unexpected, reflexively they were manageable. The challenges that Charmaz and others experience with North American Research Ethics Committees (i.e. IRBs and REBs) have a great deal to do with the novelty of this robust methodology. Yet even when working with extremely vulnerable forensic psychiatric clients, ethical assurances were manageable.

DEFINING THE WALKING INTERVIEW

In recent years, the newly developing Mobilities Paradigm (Sheller & Urry, 2006) is gaining support across multiple disciplines. The mobility paradigm offers a solution to the increasing interest in aspects of life that are physically mobile and the desire to explore the link between self and place (Evans & Jones, 2011; Hein et al., 2008). There is a need to question the traditional sedentary nature of social research (Sheller & Urry, 2006) and the walking interview, a method used within the mobility paradigm, helps address that challenge.

Located predominantly within geographical literature (Anderson, 2004; Evans & Jones, 2011; Holton & Riley, 2014), social scientists' use of walking interviews (where the researcher walks alongside the interviewee)

as a method of collecting data has increased over the past number of years (Butler & Derrett, 2014; Carpiano, 2009; Clark & Emmel, 2010; Hall et al., 2006; Jones et al., 2008; Kusenbach, 2003). Though mobile interviewing is still at the emergent stage as a method of data collection, its methodological roots go much deeper. Interest in how people create and use the spaces and places where they live and work can be seen in Louis Wirth's (1938) work on urbanism and Oscar Newman's (1976) work on crime prevention and neighbourhood safety. The walking interview does show great potential to shed light on how individuals frame and understand the spaces they use in their lives (Jones et al., 2008).

The walking interview can provide the interviewer access to the interviewee's attitudes and knowledge about their physical environment (Evans & Jones, 2011) and the connection or alienation they have to the social networks they have within it (Clark & Emmel, 2010). It provides an opportunity to explore issues the interviewee may have in relation to place (Jones et al., 2008). At the same time the interviewees' narratives regarding their experiences of place can be challenged and reconstructed, the walking interview provides an opportunity to explore how experiences are changed and reframed over time (Holton & Riley, 2014), thus making engaging with the interviewees' understanding of place easier. The interviewer can gain insight into the interviewees' physical capability while engaging in a usual routine, where a description in a sit-down interview may not adequately represent their reality (Butler & Derrett, 2014).

In contrast, interviewees within sedentary interviews can drift from the topic when their knowledge on the given area has been exhausted. Evans and Jones (2011) found interviewees in walking interviews tend to talk more spontaneously, and more specific information regarding the place being explored is produced. By being outside of the formal research format the walking interview

can also improve the interviewees' comfortability with being in the research (Trell & Van Hoven, 2010). Talk becomes easier when walking; the natural occurrences when walking replace the unnatural pauses that happen in a sedentary interview. Crossing the road, walking up a hill, turning a corner are natural pauses that will bring the conversation back to the everyday (Hall et al., 2006). Completing walking interviews also pose a number of challenges both ethically and organizationally and these will be explored further in the chapter.

There are a number of different formats the walking interview can take and are seen on a continuum from having the route determined by the interviewee through to the route being undetermined and finally through to the route being completely determined by the interviewer (Evans & Jones, 2011). I will outline the 'going-along' interview, 'participatory' interview and the 'bimble' interview as these are the ones I reviewed for my research.

Go-along Interviews

Go-along interviews are regarded as a mix between an interview and interviewee observation. During the outing the interviewer asks questions, listens and observes the interviewee (Kusenbach, 2003). The go-along interview occurs when the interviewer accompanies an interviewee in on an outing that would normally occur. The route is completely determined by the interviewee (Evans & Jones, 2011). It is important during these go-along's that the interviewer is following the interviewee in their natural environment, while they are completing their normal routines ensuring these are occurring on the usual day, at the usual time and following the usual route they would normally take (Kusenbach, 2003).

Carpiano (2009) found the go-along works to reduce the power imbalance, especially in marginalized populations, the interviewee works as a tour guide, deciding what

is important and should be shared with the interviewer, allowing the interviewee to have input into the research process. Thus, the go-along interview is viewed as a more inclusive process (as opposed to the sit-down interview); it is more of a partnership.

Carpiano (2009) used the go-along interview as a unique qualitative method to study health issues in the local environment, examining the physical, social and mental dimensions of place and how they interact with each other for an individual over time.

Participatory Walking Interviews

Participatory walking interviews gain an understanding of the interviewee's sense of place and neighbourhood attachment. The interviewee has the opportunity to show their environment and explain the significance rather than using a description with the interviewer. By being in a natural environment the articulation of thoughts become easier, which in turn provides depth to the interviewers understanding (Clark & Emmel, 2010).

The difference from the go-along interview is, rather than following an interviewee on a natural outing that would have occurred if the interviewer was not present, this interview takes place while walking a route that the interviewee has determined is in their familiar neighbourhood (Clark & Emmel, 2010). The routes used for the walking interview are not to be considered representative of people's actual everyday routines and habits but rather indicative of how they think about their neighbourhoods. Interviewees determine the route, length of time and what they want to show the interviewer (Clark & Emmel, 2009, 2010).

Bimbling

Bimbling is described as the practice of going for a walk to blow off steam, that is, walking or wandering with no clear aim (Evans, 1998

cited in Anderson, 2004). Bimbling has now been used as a method for collecting data in qualitative research mainly when exploring activism and when there is a need to remove the interviewee away from an environment, which is politicized due to protests taking place (Anderson, 2004).

This ‘talking while walking’ interview is conducted in a similar fashion to the previous two methods however the route taken is not necessarily known by either the interviewer or interviewee. The act of walking provides the opportunity for the interviewee to recollect experiences and to articulate them (Anderson, 2004) rather than being concerned about the specific location (Jones et al., 2008).

Photo Elicitation

Photo elicitation differs from walking interviews but shares some similar elements. Similarities include providing vulnerable interviewees an opportunity to have a voice within research and allowing for the facilitation of inclusive research (Fullana et al., 2014). Those with long-term mental illness can sit passively during traditional qualitative talking interviews, waiting for guidance on how to answer questions (Erdner & Magnusson, 2011). Using photos to direct an interview can overcome the difficulty many people with long-term mental illness can have in regards to spontaneous verbal communication (Erdner et al., 2009).

The significant difference relates to mobility. Photo elicitation is a static method where interviewees sit and look at photos and recall experiences or reflect on their understandings; they are removed from the place they are looking at. The walking interview allows interviewees to engage with the place they are reflecting on while moving through and interacting with the place, and this allows for spontaneous memories that may not have occurred while sitting in a room.

Cannuscio and colleagues (2009) used a walking interview combined with photographs

to explore health risks of the environment the interviewees lived in. The researcher carried the camera and took photos of areas the interviewee identified. These photos were then used to elicit further information from the interviewee in a follow-up interview. Fullana and colleagues (2014) used photo elicitation in an aim to improve the participation of people with significant mental illness in research. I believed the use of a walking interview including a camera would be beneficial for my research because it would enable me to gain a fuller picture on how the client interviewee was connecting to the community in which they were living.

TRANSITING THE HOSPITAL

Like the majority of the population, people in forensic psychiatric services undergo a variety of transitions. Many are forced upon them, and their perception, often based on reality, is that they have limited control over these processes. Moving to the community after significant periods of time in psychiatric hospitals is challenging for the majority of those making this transition (Coffey, 2012b; Grusky et al., 1985). Transitioning from a hospital setting to the community requires a person to be aware of the changes occurring and to be able to adapt to the ways of doing a task, as well as to how they think about it.

Leaving the support and structure of a ward, managing budgets, and adapting to new accommodation are just a few of the processes those leaving hospital have to make that can be challenging (Nolan et al., 2011).

Assessment and the management of risk to others is one of the fundamental focuses for mental health professionals within forensic psychiatric services (Coffey, 2012b; Doyle, 2011). Ensuring a successful outcome of transition from hospital to the community is important for both the person and the community. Keeping the community safe and

facilitating the recovery of the person is a balancing act for forensic psychiatric services in New Zealand (Pouncey & Lukens, 2010; Simpson & Penney, 2011).

There is an acknowledgment by a range of authors that there is very little literature available regarding moving forensic psychiatric clients to the community. Past research has been focused on risk and recidivism and very little relates to how forensic psychiatric clients attempt to adapt and transition towards an ordinary lifestyle, leading some authors to call for research that incorporates the forensic psychiatric clients' voice (Bjørkly, 2004; Coffey, 2012a; Jamieson et al., 2006; Kaliski, 1997; Viljoen et al., 2011).

The research project aims to contribute to the body of knowledge in this field and to be of use within this clinical area of practice. The main research question asks: How do those moving to the community within a forensic psychiatric service adapt to this situational change? A number of sub-questions will also be addressed including: What influences the transition experiences of those moving to the community within a forensic psychiatric service? Do people and the environment influence how a person engages in their transition? What would transition success look like?

Gaining Ethics Approval

Gaining access to the client interviewees for this research was a complex and multilayered process. I was required to obtain ethics approval through my university's ethics committee and to gain approval and final sign-off from multiple areas within the health board within which the regional forensic psychiatric service (RFPS) was situated. The approval of the Specialist Mental Health Service (SMHS) research committee had to be sought, and once their approval was gained, I was required to obtain the approval of the RFPS's directorate. Finally, the General Manager of the SMHS was required to sign off on the research. Gaining approval for all

of these points was a complex process that often took multiple paths and was not a straightforward linear process.

I estimate the process of gaining access to the client interviewees took approximately nine months. My starting point was to make contact with the RFPS, if I was to be successful then the development of the project needed to have them connected with the outcome. I spent many weeks communicating via email and telephone with the service manager. I wanted to ensure the project I was developing would gain the support of the service. The service manager advised that though the service supported the project in principle, I was required to gain the multiple levels of approval listed earlier before I could begin recruitment. I received the advice that the service supported the project in principle via an email, and this ended up being an important document that was used in my subsequent ethics application.

After approximately three months of consultation, I submitted my application to my university's ethics committee and my research proposal to the SMHS research committee. I was required to also send my completed (but not yet approved) ethics application to the SMHS research committee at the same time. The RFPS supported the use of the clinical team to identify appropriate client interviewees who were living in the community or who were on the pathway to moving permanently to the community. The clinical team had the best knowledge of the clients regarding their mental wellness and ability to engage in the research. All eligible client interviewees were invited to join though not all accepted. Each eligible client interviewee was deemed to be capable of making decisions regarding their inclusion in the research because they were either living permanently in the community, and making decisions routinely regarding their day-to-day lives, or were preparing to enter the community in the near future.

There were a number of strategies I applied to aid the approval process. I highlighted the extensive experience I had not only with

working within forensic psychiatric services but specifically the service within which I hoped to complete my research. When I first made contact with the RFPS service manager, I had not met the person before as they were new to the position since I had left. That person commented to me they had ‘heard good things about me’, through conversations with others. My previous experience and my relationships within the RFPS were important factors in allowing me access to the clients. Though I was now an outsider, my previous insider status was what gained me access. That previous insider status also provided the RFPS with confidence in my ability to carry out this research.

I also met with the manager of the university’s ethics committee prior to submitting my application. This was to reinforce my knowledge and skills in an attempt to build confidence in my ability to carry out this research. It was an important meeting as it allowed me to build a relationship with the ethics committee. The meeting gave me an opportunity to talk through some of the decisions I had made regarding my project and to discuss with the manager the support I had already from the RFPS for the project. I am in no doubt my experience of working within this specific RFPS aided in my subsequent ethics approval.

The following criteria, which match the code of practice of the safety of social researchers outlined by the Social Research Association (n.d.), were included in my ethics application and related specifically to the walking interview and the use of a camera while on the walking interview. They were included to ensure the safety of the client interviewee, the researcher and the community:

- The client interviewee would indicate what they would like photos to be taken of during the walking interview; however, the camera would be carried and used by myself. Many of the client interviewees are well known publicly due to having a high media visibility. At times members of the public monitor them so it was important they were not put in a position where there might be confusion about what they were doing.

- No photos of people would be taken, even in public places.
- The walking interviews would only occur in the hours of daylight and would not commence close to twilight.
- The walking interview would occur in a public place and would not go through isolated areas. If the client interviewee advised the only place they wanted to walk was in an isolated area, then the walking interview would not commence.
- I would meet the client interviewee at the agreed location to commence the walking distance. I would not transport the client interviewee using my personal vehicle or call them using my personal phone. The client interviewee only had my work contact details.
- Connecting to the client interviewees case manager would occur prior to the walking interview begin arranged to check if anything had changed for the person and to ascertain if their mental state was settled. This was a check-in only, no information regarding any information the client interviewee had shared in previous meetings was given.

Another factor I included in my project related to the selection of pseudonyms for the research. I wanted the client interviewee to select their own pseudonyms so that they felt connected to them. It was also a way for them to know which quotes came from them when they were going through the final results. They were advised not to select a name that was similar to their real name or to choose a nickname they were known as.

The final ethics approval came through a month after it was first applied for. However, the SMHS research committee wanted more information regarding the project. It was at this point that I experienced the most significant challenge to obtaining my approvals. This committee oversees all research carried out within the SMHS so my research would not proceed without their approval. There was only one qualitative researcher on the committee who was not familiar with walking interviews or how a camera might be used with them. I was advised I needed to reassure this particular member because the rest of the committee would be guided by their viewpoint.

To reassure the SMHS committee, I forwarded literature that showed successful use of both the walking interview and a camera with clients with enduring mental illness and diagnoses similar to those expected within a RFPS. Along with the literature, I also forwarded the final ethics approval I had gained from my university. Soon after these were submitted I learnt I had also gained approval from SMHS research committee. I believe two factors contributed to gaining SMHS research committee approval: the RFPS had reinforced with the SMHS research committee they were supportive of the project and wanted to see it go ahead, and my university's ethics committee had granted final approval.

It took another four months to obtain official approval from the RFPS directorate and the general manager of the SMHS. I was required to provide nothing further to aid with the approval process, this was the time it took to move between the different levels. Only after I had received the final approval from the general manager of the SMHS did I begin the process of recruitment.

USING THE WALKING INTERVIEW

The walking interviews I used for my research were a combination of the three I have outlined above. No interview was distinctly of one particular type: I found some client interviewees wanted to chat about a range of topics while we were walking rather than specifically talking to me about the location we were walking through – they were a combination of the participatory design and the bimbly walking interview. Another took me on a walk he would have done without me, on a route he usually walked on that day and time each week. Once we had arrived at the location, he wanted to show me around, keen to show me where he spent his time and to talk to me about that location. His walking interview was a combination of a go-along and a participatory design.

I carried a camera and was to take photos of areas which the client interviewee indicated were important to them. Those photos were to form the basis of a subsequent interview. I found this did not occur as I had planned. The client interviewees only occasionally indicated when photos should be taken; I found that they were looking to me to direct this process. It may have been because I was carrying the camera, so they were not as connected to the activity. Though they had been prepared regarding the use of the camera on the walk, some of the routes had changed from the original planned walk, so the client interviewee may not have had time to think about what was important on the route that we did take. The ability to think abstractly for this client interviewee group is challenging (Ferguson et al., 2009), so the idea of looking at items and relating them to the importance of their transition to the community may have been difficult too.

The following are examples from some of my walking interviews, they highlight the information that can be gathered from these interviews that do not relate to the specific content of the conversation of the interview. The pseudonyms used are the ones each of the client interviewees chose for themselves.

Peter

Peter had initially indicated he would like to complete his walking interview at the beach. We had agreed a day, time and a place to meet. That was as far as we had organized his walking interview because I had found they worked better if the walking interview was allowed to progress naturally. Peter happened to live in a flat close to another client interviewee, Sebastian. I had arrived at this location to meet with Sebastian. This was already arranged, so he was expecting me. I was scheduled to meet with Peter later that day at the beach to complete the walking interview. Peter was waiting for me when I arrived as Sebastian had told him I was coming. He

requested a change in his walking interview location because his car needed petrol and he did not have finances to get more for that day. He wanted to walk around his local suburb so that he did not need to use his car. He also requested an earlier time as the weather was not great and he wanted to complete it before the rain was scheduled to arrive. I agreed to these because I could not take Peter in my personal car to the beach, the transporting of client interviewees in my personal car was not an option, as stated earlier, and this was consistent with the RFPS policy. The walk with Peter around his local suburb was nevertheless very useful and I gathered a lot of information about Peter's hopes and dreams for his future in the community by walking this new route. During the walk, I asked Peter about the beach. I wanted to know the significance of the beach to his transition, especially since we could not walk there. Peter advised he rarely went to the beach and it was not significant to him at all, in fact he said 'oh I don't really spend time there, I just thought you might like to go there'. This spoke volumes to me about Peter's interest in my experience of the walking interview and his desire to show off the points of interest of his city.

Smelly

Smelly was a client interviewee who still remained within the hospital and so our walking interview occurred within the boundaries of the hospital grounds. During the course of the research Smelly increased his time in the community to the point of being discharged to live in the community fulltime; however, at the time we completed his walking interview he was predominantly in hospital. Smelly had advised that he usually completed the walk we were to take each day and sometimes twice a day. He explained he walked the hospital grounds boundary and this usually took approximately 30 minutes. When walking with Smelly I learnt he literally did walk the boundary without ever crossing over it. At

times this was beside very high fences and we would walk just a few centimetres from the fence. Even squeezing between parked cars and the fence, rather than walking around the car, to ensure he kept as close to the boundary as he could. At other times there was no fence to indicate the boundary. However, it was clear Smelly was well aware of where the boundary was. When questioned why we were walking on the grass rather than the asphalt path just beside us Smelly advised the grass was within the hospital boundary however the asphalt path was not. It was very important for a client transitioning not to be caught off the hospital grounds or access to future leaves were at risk. Smelly was aware he may be seen off the ground by members of the public and the likelihood of this being then reported to the service was high and that would then likely jeopardize any future access to the community.

Sebastian

Sebastian had recently transitioned to living in the community six nights a week when his walking interview was completed. He had moved from four nights a week to six just a few weeks earlier and spending that amount of time in the community independently was still relatively new for him. Sebastian had requested walking around the botanical gardens for his walking interview as it was a place in which he had spent significant time during his transition; he found it restful and it was a place he could enjoy. My insights on this walking interview relate more to Sebastian's behaviour on the walking interview rather than the location of the walking interview. Sebastian had been advised (as all of the client interviewees were) that at the start of the walking interview he was to direct where we would walk. I was interested in seeing what he wanted to show me rather than directing the walking interview myself. Within the botanical gardens there are multiple paths that cross each other throughout the

gardens. Also the public were permitted to walk across the grass. Sebastian set off following the established paths, but I noticed as we got closer to a point where the path we were walking on either split into two or crossed another, Sebastian would slow his walking. As a result, I would slow my pace and then Sebastian would slow his pace even further. At times I would find myself slightly in front of Sebastian rather than walking beside him. I realized Sebastian was waiting for me to direct where we would walk rather than him taking this role. I immediately reminded Sebastian he could decide the direction and we would set off at a normal walking pace again in the direction Sebastian had selected. This happened a number of times during the walking interview. At times I got a sense from Sebastian he viewed the interview more like an escorted outing rather than a walk he was controlling. This may have been due to Sebastian only recently increasing the amount of time he spends in the community. When clients are in hospital and have been given an opportunity to visit the community accompanied by staff, it is the staff who will often make many of the decisions. Sebastian may have automatically returned to previous ways of being without thought and viewed myself similar to a staff member.

The insights I gained into the client interviewees' transitions to the community by completing the walking interviews was invaluable. The act of walking alongside the client interviewee allowed me to connect to their transitional journey. The walking interview provided me with opportunities to observe interactions that could not have been explained in a face to face interview or captured by using photos.

The use of the camera within my research did not prove to be as valuable as I first thought it might. I believe the camera could have been more useful had I prepared the interviewees for its use on the walking interviews better than I did. I discussed the use of the camera with each interviewee prior to them signing the consent form for the research and again

immediately prior to the walking interview commencing. However, what may have been helpful was to talk through examples of how the camera could be used on the walking interview, using pre written scenarios unrelated to transition. This may have helped the interviewees with their understanding on why the camera was being used.

EIGHT ETHICAL DILEMMAS

There were many ethical dilemmas either I planned for or had to address as I became aware of them during both the walking interview and the research project as a whole.

First, I was aware that when walking in public spaces there was a likelihood that we could come across a member of the public that was known to either my interviewee or myself. Acknowledging this and putting strategies in place for managing the potential of a person wanting to speak with either the interviewee or myself was important to ensure their safety and confidentiality. Prior to the walking interview occurring we spoke about what the interviewee wanted to do if this situation occurred. We were mindful that this might be different depending on who the person was that approached. (As I was completing the research 400km away from my home, the likelihood of me meeting someone I knew was minimal and didn't occur.) Two interviewees did meet people they knew, one of the interviewees didn't want to engage with the person they knew. I stepped back so he didn't feel like he had to introduce me. The interviewee cut off the member of the public who was attempting conversation, advising them he was busy and couldn't talk. He then started walking away and I followed. We continued with our walking interview as though we had not met the member of the public. The second interviewee had a different response to the member of the public he knew. The interviewee introduced me and explained to them what we were doing. We

spent only a few moments speaking before the interviewee said goodbye to the member of the public and then we continued on with the walking interview. Both meetings showed the client interviewee leading how we would respond to members of the public they knew. My engagement with the member of the public was very much directed by how the client interviewee reacted.

Second, all of the walking interviews occurred in public places and most had members of the public milling close by. The client interviewee was aware the walking interviews were being recorded as they were shown the recorder (a small digital recorder) and the lapel microphone I was wearing. The recording device was chosen as it was small and easily worn so as not to be obvious to those passing us by. The recorder was set up to only record within 1–2 metres so it picked up the interviewer's and interviewees' voices only. It was important I kept my voice at a level that was appropriate for the area I was walking through so as not to highlight what we were doing. At times members of the public were close and could potentially hear our conversation. Client interviewees were reminded of this before the interview started. There was only one occasion when we were in such very close proximity to the members of the public that our conversation could be overheard and that was when travelling in the elevator between floors of a building we were walking around. Conversation between the client interviewee and myself stopped for this time and commenced again after exiting the elevator and moving away from the members of the public. Though this had not been discussed prior to the interview it happened naturally. Similarly, the members of the public who entered the elevator with us also stopped talking for the duration.

Third, the use of the camera needed to be considered carefully. Though it was agreed that no photos of people would be taken in public spaces this did present some challenges. During one walking interview where we were walking through the botanical

gardens, one client interviewee had indicated a specific area of interest. He had connections to it through his own childhood and during the walking interview he had reminisced about this place and its significance to him. However, taking a photo was going to be impossible due to the number of children that were exploring the area at the time. The photos weren't going to be used anywhere other than as a probe for the next interview; however, protecting the client interviewee and any potential negative impact on him was paramount. No photo of this area was taken. We spent more time talking about the area than I would have done if I could have taken a photo in an attempt to gather as much information as I could. Consideration of the safety of the client interviewee outweighed the benefits that would have come from taking the photo.

Fourth, transportation of the client interviewee to their walking interview location was also a challenge at times. All of the walking interviews were planned to occur away from the client interviewees' homes. This meant they were required to transport themselves to the starting point of the walking interview. Two could walk the short distance, but all others needed to either catch a bus or drive themselves to the starting point. This client group fit within the lower socioeconomic group categories and they have limited funds to spend money on extras. One client interviewee asked to change their location because of a lack of funds to fill his car with the petrol he would need to get him to his original walking interview location. I needed to be flexible to accommodate these requests as I did not want the walking interview to be a burden to the client interviewee. I could have potentially avoided this challenge if I had factored in a budget that would have provided finances to pay for petrol or taxis for the client interviewees.

Fifth, safety of myself was an ethical issue. I had a very clear set of processes in place that I followed prior to commencing a walking interview. My safety plan included

checking in with staff regarding the mental wellness of the person, making sure the person was still able to attend, and checking with the person themselves to make sure they still wanted to participate. I carried a phone with me in case of an emergency and advised staff of my location. I also gave an estimation of when I would be returning although this could not be exact because the client interviewee directed the walking interview. Staff also had my contact details if they needed to get in contact with me. On one occasion I cancelled a walking interview because at my check-in with staff I was informed the client interviewee was becoming mentally unwell and they did not recommend going out with him. Though the client interviewee was still living in the community and participating in a range of activities in the community, I did take the staff's advice and waited till the client interviewee had settled mentally as I did not want to add any unnecessary pressure to the person, or put myself at risk.

Sixth, client interviewees were unable to have my personal phone number to call if they wanted to change any of the arrangements. They were heavily reliant on me making contact prior to their interview when I checked in to make sure they still wanted to participate. I did give them my work phone number; however, it was a landline and not a cell phone so once I was travelling it was difficult to get hold of me. Twice I arrived at the location to meet with a client interviewee and they were not present. On speaking with staff I found out the client interviewee had emailed me to advise they needed to change the plans at short notice because of something coming up for them; however, they couldn't ring as I was travelling already. This is another challenge that could have been overcome with forethought. If I'd had a cell phone number which I could have given to the client interviewee that wasn't my personal number, then they could have communicated with me more easily.

Seventh, as a safety precaution, I was required to ensure the walking interview did not occur during the hours of darkness or in

isolated locations and on the whole this was not an issue. However, for my walk with Joe I did need to clarify what time his classes were and if I would be walking with him after twilight. Potentially, this could have impacted significantly on the walking interview as his classes were in the early evening. Fortunately, due to the season the light was not an issue; however, the walking interview could have been compromised had I not been able to walk where Joe had wanted. All of the other walking interviews were able to be carried out during the day. None of the client interviewees requested their walking interview to occur in isolated areas. None of the walking routes travelled through isolated areas. This may have been because I had discussed this with each of the client interviewees prior to establishing the rules that governed where we could walk. None of the client interviewees expressed disappointment about not being able to walk where they would have preferred.

Eighth, at times I experienced an insider/outsider conflict of interest (see Toy-Cronin, Chapter 30, this *Handbook*). Due to being employed within the RFPS almost eight years ago I had knowledge of processes within the service, I knew a number of the staff and I also knew a number of the clients who joined the research project. When checking in with staff prior to holding an interview with the client interviewee I would gain extra information about the person that I believe I would not have been given had I been unknown to the service. Knowing this information then influenced how I interacted with the client interviewee; it influenced how I asked questions. For example, when meeting one client for the first time, I checked in with the staff member regarding his mental state. I had not met the client before so I had no previous knowledge of him. I knew the staff member; I had worked with them previously over many years. I was told a lot of information about the client's index offence, what had happened and the staff member's view of how lucky he had been to get the outcome he had. They gave me information regarding the goals the

client was working towards and their opinion on whether they were realistic or achievable for him. I went into the initial meeting with the client believing the information I had already gained could influence the direction the interview took and potentially taint the way I received information he gave me. I was aware of this so took reflexive measures to overcome this prejudice.

SECOND THOUGHTS

‘If I was to complete this research again, what would I do differently?’ is a very difficult question to answer. I believe that ensuring any plans put in place are flexible is important, as many of the factors that will impact on the walking interview will be out of the researcher’s control. Making sure anticipated ethical dilemmas have been addressed and being aware there will be other ethical dilemmas that have not been anticipated but will need addressing is crucial.

Some of the decisions that I made that I would do differently include:

- I would ensure I had factored in a budget to cover petrol or taxi expenses for the client interviewees so that they were not burdened by the experience.
- I would ensure I had a method of communicating with me for the client interviewees that was simple, effective and did not cost them anything.
- Keeping the interviews flexible is important; though I had set out to use a specific type of walking interview I soon realized that this was not necessarily useful. Ensuring the walking interview meets the needs of the client interviewee and the research is what is important.
- I would spend more time discussing the use of the camera and use hypothetical examples as a way of increasing the interviewees understanding of how the camera would be used in the walking interview

Overall, I am happy with the plans I had made to complete this type of interview with this vulnerable research population. I had

anticipated the majority of the ethical issues that might arrive and had a plan in place to manage them. The last point I would make is that an ongoing relationship with the ethics committee is vital; being ready to return to the ethics committee to request amendments if necessary is helpful.

CONCLUSION

Within the chapter I have addressed the two comments used to frame this work. Ensuring the voices of the forensic psychiatric client were included into the project was important when looking at how they transitioned from hospital to the community. Including a method that would ensure their engagement was a value-based decision and successfully captured the client voices. The walking interview has a number of ethical challenges that must be addressed to ensure the safety of both this vulnerable population and the researcher. The chapter has outlined the ethical dilemmas I identified and the strategies I used to address these, providing evidence that concerns raised by universities ethics committee and the service can be successfully addressed.

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Appendix B

From: [Cate Kearney](#)
To: [Penelope Kinney](#)
Cc: Subject:
Date: FW: PhD research
Attachments: Wednesday, 24 September 2014 4:58:47 p.m.

Hi Penelope, I did receive your email but ... thank you for encouragement to complete. Your research has been discussed by the Forensic Service and is supported in principle.

Not sure if you went through our SMHS divisional approval process last time so I have attached the Research Locality Assessment form (attached). The process is that once you have your Ethics Application underway you would also forward that documentation to us with the Locality Assessment.

As you are not employed here and are asking to access patient information, patients and staff there would be consideration of privacy and consent for research issues.

I have cc'd in Barbara Bee who is the Research Committee Coordinator. She can answer your questions about our processes. Once you have everything together you can send to Barbara and we will table for the Committee (I'm chair of the Committee).

When the research is approved to take place in SMHS, then the Forensic Directorate has a role of staying in touch with you and getting progress reports from you.

Thanks for your email and good on you for carrying on to complete a PhD. Unfortunately I can't meet with you this week as I am booked but happy to respond to emails

Kind

regards

Cate

Appendix B

From: [Henare Te Karu](#)
To: [Penelope Kinney](#)
Cc: [Cate Kearney](#);
Subject: RE: PhD research Friday, 10 October
Date: 2014 6:51:47 p.m.

Tena koe
Penelope

Ko Tararua te
Maunga Ko
Ruamahanga te
Awa Ko Te Ore
Ore te Marae
Ko Nga Tau E Waru te Wharenu
Ko Ngati Kahungunu kite Wairarapa
te Iwi Ko Takitimu te Waka

Tenei to mihi kia koe mo to kaupapa
korero

Thank you for your email. Kaye Johnston and Alfred Dell'ario is the is the Service Manager
and Clinical Head for Te Korowai Atawhai respectively

I am pleased to read that Te Pora was involved with your Masters. I am sure she would have
provided you with the necessary cultural input.

You have set out your programme well, especially around the boundaries of Pukenga Atawhai
not being permitted to be involved. I am reminded what Matua (Professor) Mason Durie
continues to say "You may discharge a client but you can't undo the whanaungatanga
that has been made through trust". So what that really means from a cultural perspective,
having the "current" Pukenga Atawhai involved (especially if he or she is known to the tangata
whaiora /client) will be more advantages to your research than not, because the Pukenga
Atawhai has already established a good relationship. The key to the door that you want to
enter for your research.

I applaud your project Penelope and would certainly welcome what we call a "korero kanohi
kite kanohi" - a talk face to face first if you can manage to include that in one of your trips to
Christchurch. Yes, I also agree I am also not one to have this type of conversation via email
and therefore please feel free to contact me so we can talk about other details I have not yet
mentioned

In the meantime tenei te mihi kia koe i tenei wa
Henare

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE TE Komiti Rakahau ki KAI TAHU

Tuesday, 23 September 2014.

Associate Professor Anita Gibbs,
Department of Sociology - Gender and Social Work,
DUNEDIN.

Tena Koe Associate Professor Anita Gibbs,

Transitioning from hospital to the community: Exploring this transition process within
New Zealand/Aotearoa forensic psychiatric services.

The Ngai Tahu Research Consultation Committee (the committee) met on Tuesday, 23
September 2014 to discuss your research proposition.

By way of introduction, this response from The Committee is provided as part of the
Memorandum of Understanding between Te Runanga o Ngai Tahu and the University. In the
statement of principles of the memorandum it states "Ngai Tahu acknowledges that the
consultation process outline in this policy provides no power of veto by Ngai Tahu to research
undertaken at the University of Otago". As such, this response is not "approval" or "mandate"
for the research, rather it is a mandated response from a Ngai Tahu appointed committee. This
process is part of a number of requirements for researchers to undertake and does not cover
other issues relating to ethics, including methodology they are separate requirements with
other committees, for example the Human Ethics Committee, etc.

Within the context of the Policy for Research Consultation with Maori, the Committee base
consultation on that defined by Justice McGechan:

*"Consultation does not mean negotiation or agreement. It means: setting out a proposal not
fully decided upon; adequately informing a party about relevant information upon which the
proposal is based; listening to what the others have to say with an open mind (in that there is
room to be persuaded against the proposal); undertaking that task in a genuine and not
cosmetic manner. Reaching a decision that may or may not alter the original proposal."*

The Committee considers the research to be of importance to Maori health.

As this study involves human participants, the Committee strongly encourage that ethnicity
data be collected as part of the research project. That is the questions on self-identified
ethnicity and descent, these questions are contained in the latest census.

The Committee suggests dissemination of the research findings to Maori health organisations
regarding this study.

We wish you every success in your research and the committee also requests a copy of the
research findings.

This Ngai Tahu Research Consultation Committee (the committee) met on Tuesday, 23 September 2014 to discuss your research proposition.

It is the policy of the Ngai Tahu Research Consultation Committee that the
researcher must provide a copy of the research findings to the Ngai Tahu
Research Consultation Committee for its review and comment.

Appendix C

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE *TE Komiti Rakahau ki KAI TAHU*

This letter of suggestion, recommendation and advice is current for an 18 month period from Tuesday, 23 September 2014 to 23 March 2016.

Nahaku noa, na


PR. NRCC

Mark Brunton
Kaiwhakahaere Rangahau Maori
Research Manager Maori
Research Division
Te Whare Wananga o Otago
Ph: +64 3 479 8738
Email: mark.brunton @otago.ac.nz
Web: www.otago.ac.nz

Thi' 'giti Tahu Jh' ".1rd1 Col1ul1.11iou CHHHEET h.1' 1111:1111enhip f10111.

Ti. NUrwn!::J o Otiiko11 Incoq,1or:11cc1
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Te U11n311),1 i n Alrwr:1k i



Academic Services
Manager, Academic Committees, Mr Gary Witte

24 November 2014

Assoc. Prof. A Gibbs
Department of Sociology, Gender and Social Work

Dear Assoc. Prof. Gibbs,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled “**Exploring the transition process of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand**”.

As a result of that consideration, the current status of your proposal is: -
Conditional Approval

For your future reference, the Ethics Committee's reference code for this project is:-
H14/139.

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

Please address the following comments before proceeding with the research:

The Committee expressed concern for the student's safety in relation to the 'walking interviews' specifically with regard to the taking of photographs. It was noted that many of the participants will have a psychotic diagnosis and the Committee seeks further clarification as to whether consideration has been given to the implications of taking photographs with people who have paranoid delusions.

While noting the above, the Committee questioned the methodology of taking photographs with this client group, and as such seeks further comment on the purpose of the photographs being taken and whether the potential consequences have been considered in these circumstances?

The Committee questioned the use of phrasing in the protocol under the heading 'Protection', page 18, sentence beginning “While no promises can be made ...” and asks for this to be re-considered.

The Information Sheet for support persons needs to be worded specifically for this group and needs to be appropriately addressed.

Appendix D

Before approval of the research to proceed can be granted, a response must be received addressing the issues raised above. The Committee expects that these comments will be addressed before recruitment of participants begins. Please note that the Committee is always willing to enter into dialogue with applicants over the points made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood. Please provide the Committee with copies of the updated documents, if changes have been necessary.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Gary Witte'.

Mr Gary Witte

Manager, Academic Committees

Tel: 479 8256

Email: gary.witte@otago.ac.nz

c.c. Professor H R Campbell Head Department of Sociology, Gender and Social Work



Assoc Prof. A Gibbs
Department of Sociology, Gender and Social Work

18 December 2014

Dear Assoc. Prof. Gibbs,

I am again writing to you concerning your proposal entitled “**Exploring the transition process of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand**”, Ethics Committee reference number

Thank you for your letter of 16th December 2014 addressing the issues raised by the Committee.

The Committee thanks you for your very thorough response.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:

Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

<http://www.otago.ac.nz/healthandsafety/index.html>

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Appendix D

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

gary.witte@otago.ac.nz

jo.farrondediaz@otago.ac.nz

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Gary Witte', is written over a faint, larger printed signature of the same name.

Mr Gary Witte

Manager, Academic Committees

Tel: 479 8256

Email: gary.witte@otago.ac.nz

c.c. Professor H R Campbell Head Department of Sociology, Gender and Social Work

Appendix E

Subject: RE: SMHS Research Committee
Date: Tuesday, 24 February 2015 at 5:09:19 PM New Zealand
From: Cate Kearney
To: Penelope Kinney
CC: Barbara Bee

Attachments:

Hi Penelope, **we have recommended your research go ahead.**

I need a few minutes to review the feedback from the Forensic Service and include this in an email for you. We will then need a few more days to get the General Manager to approve your research
My apologies for the delay, I will be on to this first thing tomorrow

Kind regards, Cate

Appendix E

Subject: RE: SMHS Research Committee
Date: Monday,30 March 2015 at 3:55:20 PM New Zealand
From: Cate Kearney
To: Penelope Kinney
CC:
Attachments:

Dear Penelope,

Thanks for your emails and no problems at all about the regularity of them.

Your research will be recommended for approval by the General Manager with the following provisos:

Recruitent

The most optimal approach is to that all patients who qualify for inclusion in the study should be invited to participate. Prior to this however, a discussion to occur with the Forensic treatment team as to the wellness of subjects at the ti me of the study and clearance with any perceived safety issues (a similar approach as used in your Masters research)

Walking Interviews/Photograpy

The Forensic Service Deputy Clinical Director has advised that there is to be discussion with the clinical team around any safety issues and if none, this methodology is approved for use with our consumers, once you have their consent.

It is Important that no pictures are taken that could identify the patient e.g. photos of their dwelling; street names etc.

SMS Research Oversight

The Forensic Service Directorate will monitor your progress with research. I am happy for you to contact me with any questions or progress reports

I will append this email to the Locality Approval form and hope to have G M approval for you before Easter.

Kind regards,
Cate

Canterbury District Health Board <small>To Pouni Hauora o Wairarapa</small>	Specialist Mental Health Service Research Locality Assessment
--	---

Step one: Researcher to complete this section

Researchers name: Penelope Kinney PhD(Candidate), Associate Professor Anita Gibbs
 (Primary Supervisor)

Research title: Exploring the transition process of moving from hospital to the community
 within a regional forensic psychiatric service in Aotearoa/New Zealand

Research location: Canterbury Regional Forensic Psychiatric Service (CDHB RFPS)
 Please attach proposal. **Attached**

Proposed timeframes
 Start: 1 January 2015
 Completion: 31 December 2016

Have you sought funding? **No** If so, from where?

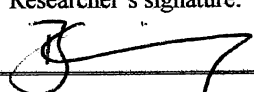
Are there any resource implications for SMHS (staffing or other costs)? **Yes** If so, what? This will relate to staff time allocation. Staff within the CDHB RFPS will be used as key liaison staff to help recruit client participants to the research. The plan is to use the occupational therapists based within each team. The role is outlined in the research protocol and an information sheet/confidentiality form has been generated for those staff. All staff involved in the development of transition plans and support of those clients transitioning to the community are also invited to participate in the research.

Is it your intention to publish any part of this research or findings? **Yes** It is hoped to publish aspects of the research (and this will also include the findings) in peer reviewed journals and to present at conferences (both national and international)

Is ethics approval required? **Yes** Ethical approval is being sought through the University of Otago Human (Health) ethics committee

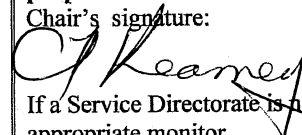
- If no, briefly state why?
- If yes, has application been made for ethics approval? Attach copy of application.
- If ethics approval has been given, attach copy of approval.

The researcher accepts accountability for ensuring that all ethical and/or regulatory obligations are met and that appropriate consultation is undertaken.

Researcher's signature:  Designation: **PhD(Candidate)** Date: **11/11/14**

Step two: Chair of Service Directorate to complete this section

The Service Directorate approves the research being undertaken and will monitor progress of the research. The proposal is recommended for approval.

Chair's signature:  Name: **Cate Kearney** Designation: **SM** Date: **30/3/2015**
 Service Manager

If a Service Directorate is not responsible for the funding function, the SMHS Research Committee will appoint an appropriate monitor. Cost Code 0362

A scanned copy of this form and proposal is to be emailed to SMHS Research Committee now

Step three: SMHS Research Committee to complete this section

Prior to approval, the SMHS Research committee will assess evidence of the following:

	Yes/no
Privacy issues	✓
Informed consent processes	✓
Information sheet	✓
Benefits and risks (including mitigations)	✓
Resource implications for SMHS (staffing and other costs)	✓
Is use of the resources recommended for approval?	NA
The proposed study meets generally accepted ethical standards	✓
The locality suitability and local researchers ability to undertake the study	✓

SMHS Research Committee approves the proposal and recommends the General Manager approves.

Chair of Research Committee signature: _____ Name: _____ Designation: _____ Date: _____

Appendix E

<i>Cole Kearney</i>	<i>C. Kearney</i>	30/3/2015
Step four: General Manager approves the research to progress.		
Name: <i>T. Gutschlag</i>	Signature: <i>[Signature]</i>	Date: <i>8/4/15</i>



Academic Services
Manager, Academic Committees, Mr Gary Witte

18 May 2015

Assoc. Prof. A Gibbs
Department of Sociology, Gender and Social Work

Dear Assoc. Prof. Gibbs,

I am again writing to you concerning your proposal entitled **“Exploring the transition process of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand”**, Ethics Committee reference number

Thank you to Penelope Kinney for her e-mail of 15th May 2015 requesting an amendment to the above study.

The Committee understands that you would like to extend the recruitment of the study to include participants who are currently within the hospital system who are in the process of moving in to the community. The Committee notes that this would provide an opportunity to compare and contrast participants anticipated experience verses their actual experience of being permanently in the community.

The Committee accepts and approves the amendment requested.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor H R Campbell Head Department of Sociology, Gender and Social Work

Appendix G

Penelope Kinney

From: Jacqueline Moore

Subject: Re: PhD study

Date: 28 September 2015 3:36:33 pm NZDT

To: Penelope Kinney

You can use email, however if you need something more formal please let me know. J

Sent from my iPhone

On 28/09/2015, at 14:20, Penelope Kinney wrote:
Hi Jackie

That is great thank you. Yes I definitely would like to include the [forensic NGO] staff. I will now go back to our ethics committee to request an alteration to my project to include those staff. Once the approval is through I will make contact again with the updated documentation for your files.

Do you know if a formal letter will be coming or can I use the email below as confirmation Pathways is happy for me to include [forensic NGO] staff into the project?

Kind
regards
Penelope

On 28/09/2015, at 9:25 am, Jacqueline Moore wrote:

I apologise for the delay, however I have good news, if you still want to include the [forensic NGO] staff you are welcome to start.

Best regards J

Jackie Moore
General Manager, Southern



Academic Services
Manager, Academic Committees, Mr Gary Witte

8 October 2015

Assoc. Prof. A Gibbs
Department of Sociology, Gender and Social Work

Dear Assoc. Prof. Gibbs,

I am again writing to you concerning your proposal entitled **“Exploring the transition process of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand”**, Ethics Committee reference number

Thank you for Penelope’s e-mail of earlier today indicating that you would now like to include in the study the staff at [forensic NGO] who have expressed an interest in the project. Thank you also for providing the e-mail from Jacqueline Moore, Southern General Manager of [NGO], indicating support for the inclusion of the staff.

The Committee accepts and approves the amendment to alter the study protocol to allow the staff at [forensic NGO] to be interviewed for the project.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor H R Campbell Head Department of Sociology, Gender and Social Work



Dear Client,

My name is Penelope Kinney and I am involved in carrying out a research project that is titled:

Forensic patients transitioning to the community

(Insert Name), (insert position) at (insert service name) has given this letter to you because you are a person who has shifted to live in the community, in the last 12 months, after spending some time at one of the forensic psychiatric hospital wards. I would like to invite you to participate in this research project. I am interested in asking you questions about your move to the community, what you did and what you thought. It will be an opportunity for you to tell me your story. I won't be asking any questions about your medications, illness or offences. This is completely voluntary and is in no way associated with your treatment.

I have an information sheet that gives you all the details about what the project is about, what you would be required to do and what will happen to the results. I would like to meet with you to go over this sheet, answer any questions you may have, and then ask you to make a decision about joining the research. If you agree to participate we would then complete the required consent form before beginning any interviews.

Please feel free to take a few days to think about this, (insert name) will come back and see you to find out if you would like to know more. If you think you would like to hear more about this project (insert name) will then make contact with me. (Insert name) will also provide me with the name and contact details of your case manager to enable me to decide the best time to come and visit you. (Insert name) will only contact me if you agree.

Thank you.

Yours sincerely

Penelope Kinney |
PhD Candidate



Forensic patients transitioning to the community

Participant Information Sheet for Clients of the service

Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with relatives or friends, before deciding whether or not to participate.

If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and I thank you for considering our request.

What is the aim of this research project?

The aim of this research is to gain a better understanding of what happens when patients like you in a forensic ward move from hospital to the community and how you settle into life in the community. We are keen to learn more about your experience of moving back to the community, what you did, where you went and what you thought about it. This study is not about your treatment or dealing with your illness. The focus of this study is about the process of change.

There isn't a lot of information available which tells us what goes on when people move back to the community after spending time in hospital. This research will use a walking interview to give us insight into what factors are important to consider when developing transition/transfer plans for people returning to the community. Understanding these factors will allow staff who are developing the transition/transfer plans and supporting people in this move back to the community ensure they cater for the needs of each person.

Who has been asked to be part of this research?

A range of people are invited to be part of the research to ensure a full picture of this move from hospital to the community is gathered. The following people will be invited and each have been given an information sheet

- All patients who have recently moved to live fulltime in the community (in the last 12 months) from any of the inpatient units.
- Staff who are involved in planning and/or supporting patients in the move to the community and while living in the community (the staff will not necessarily have been or are involved with your care)

Your decision to be part of this research is completely voluntary.

What does this mean for you?

Appendix J

The potential benefits that will occur from this research will primarily be about ensuring that new transition plans being developed in the future will take into account the needs of each individual.

If participating in this research brings up concerns for you that you need to speak with someone about then you are encouraged to contact the researcher, on the contact details below, and your case manager.

What will participants be asked to do?

Should you agree to take part in this project you will be asked to participate in up to three different interviews.

1. The first interview will be done by sitting down and talking to you, for about an hour. This interview will occur in an interview room of the outpatient clinic you are currently supported by. Questions about your experience of moving to the community will be asked. The questions will focus on how the move was for you, what you did and what your experience was. At the end of this interview we will agree on a meeting point and a day and time for the walking interview.
2. In the second interview you will be accompanied on a walk around an area that was important to you during your move back to the community. It might be an area you regularly went for a walk in, or it might be around an area you spend a lot of time at now. The interview will occur during daylight hours and at a time that is convenient for you. A camera will be brought and the researcher will take photos of things that were or still are important in your move to the community. Photos will only be taken when you indicate they should be taken. Photos will not be taken of any people. During the walk we will talk about the area that we are walking through so that a better understanding of how this area is important to you and your move to the community.
3. The third interview will be done by sitting down and talking to you, for about 30 minutes. During this interview the researcher will check out with you some of the things that have been found from the earlier interviews and it will be a time to make any changes to what you've said. Copies of the photos taken during the walking interview will be brought and left with you to keep.

You will be able to stop at anytime, not answer questions or change your answers if you want to during any of the interviews. Personal information will be collected once and will be kept to a minimum and will relate to the length of time you've lived in the community, length of time you were in hospital, length of time you spent moving to the community, where you currently live, your age range, your gender and ethnicity. All interviews will be recorded using a voice recorder. You can choose to participate in one, two or all three interviews.

You will be provided with a \$20 grocery voucher from a supermarket of your choice at the completion of the first interview in recognition for the travel you have completed to attend that interview.

Can I have someone with me during the interviews?

Yes you can. You are welcome to have a support person who will accompany you on any of the interviews. This person **will not** be from your treating team (ie it will not be

your nurse, occupational therapist or any other team member). This is so you can feel free to say what ever you think. The support person should be someone you feel comfortable with and if you are unsure who to ask I can give you the names people such as a consumer advisor, chaplain or patient advocate and help you contact him or her if you would like.

This person will be in the interview with you to provide support although he or she won't be answering any of the questions for you.

Who will have access to the data and where will it be stored?

Two people will have access to this data in its raw form: The researchers below, and for a limited time, a transcriber employed by them.

The results of the project may be published and will be available in the University of Otago library but every attempt will be made to preserve your confidentiality. You are most welcome to request a copy of the results of the project should you wish.

The data collected will be securely stored in such a way that only those mentioned below and the transcriber will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for at least ten years, after which it will be destroyed.

How will your confidentiality be protected?

So that you feel comfortable in answering the questions as you want I promise to ensure the things you say during the interviews will remain private. Your answers will not be shared with your treating team or be written in your notes. However, if at any stage you give information that raises concerns about your safety or the safety of others then your treating team will be advised. You will be told if this needs to occur.

Your privacy will be protected except where your own safety or that of someone else is at risk.

Can I change my mind and withdraw from the project?

You can decide not to participate. You won't have to explain and nothing will happen because you decide not to join in. If you choose to be involved, you can change your mind and stop participating in the project at any time, without having to give any reasons. You can also withdraw any information that has already been supplied until two weeks after each interview has been completed.

You can refuse to answer any particular question, and ask for the voice recorder to be turned off at any stage.

Any questions?

If you have any questions now or in the future, please feel free to contact either:

Name: Penelope Kinney Position: PhD Student Department: Sociology Contact phone number: Ph. 03 479 6186 or 0800 762 786 ext 8186 Email: kinpe190@student.otago.ac.nz	Name: Anita Gibbs Position: Associate Professor Department: Sociology Email: Anita.Gibbs@otago.ac.nz
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Appendix J

This study has been approved by the University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



Forensic patients transitioning to the community

Participant Consent Form for Clients of the service

Name of participant:.....

1. I have read the Information Sheet concerning this study and understand the aims of this research project. I have had sufficient time to talk with other people of my choice about participating in the study.
2. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
3. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage. I know that I am free to ask for the voice recorder to be stopped for a period of time and be restarted only if I wish.
4. I know that I am free to ask for a support person as outlined in the Information Sheet to join me at the interviews if I wish.
5. I know that if I say or do anything during the interviews that raises concern about my safety or others safety then my treating team will be advised. I will be told when this will happen.
6. I know that selected photos taken during the walking interview maybe used in future publications and/or presentations and any features which may identify me will be removed or altered before being included.
7. I know that the interviews will explore my move to the community and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) , and /or may withdraw from the project without disadvantage of any kind.
8. I know that when the project is completed all personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.

Appendix K

9. I understand that the results of the project may be published and be available in the University of Otago Library, and that any personal identifying information will remain confidential between myself and the researchers during the study, and will not appear in any spoken or written report of the study.

Signature of participant:

Date:



Dear Staff member

My name is Penelope Kinney and I am involved in carrying out a research project that is titled:

Forensic patients transitioning to the community

The aim of this research is to gain a better understanding of what happens when patients in a forensic ward move from hospital to the community and how they settle into life in the community. It is important for the research that forensic psychiatric staff involved in this process are included.

If you are a staff member who is involved in one, two or all of the following:

- Developing transition plans for patients leaving hospital when moving to the community
and/or
- Supporting patients while they are spending time in both the community and hospital.
and/or
- Supporting patients living fulltime in the community.

I would like to invite you to participate in this research project. I am interested in talking to you about what you do during this process, what you think about and what you observe during this time. This is completely voluntary and is in no way associated with your work.

I have an information sheet that gives you all the details about what the project is about, what you would be required to do and what will happen to the results. I would like to meet with you to go over this sheet, answer any questions you may have, and then ask you to make a decision about joining the research. If you agree to participate we would then complete the required consent form before beginning any interviews.

Please feel free to contact me on kinpe190@student.otago.ac.nz or (03) 479 6186 or 0800 762 786 ext 8186 if you are interested in hearing more about the research and I can arrange a time for me to meet with you.

Thank you.

Yours sincerely

Penelope Kinney
PhD Candidate



Forensic patients transitioning to the community

Participant Information Sheet for Staff of the service

Introduction

Thank you for showing an interest in this project. Please read this information sheet carefully. Take time to consider and, if you wish, talk with others, before deciding whether or not to participate.

If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the aim of this research project?

The aim of this research is to gain a better understanding of what happens when patients in a forensic ward move from hospital to the community and how they settle into life in the community. We are keen to learn more about your experience of developing transition plans for patients and/or supporting patients during the move out of hospital and/or supporting patients while they live in the community. We are keen to hear about what you do, what you observe and what you think. The focus of this study is about the process of change.

There isn't a lot of information available which tells us what goes on when people move back to the community after spending time in a forensic psychiatric hospital. This research will give us insight into what factors are important to consider when developing transition/transfer plans for people returning to the community. Understanding these factors will allow staff who are developing the transition/transfer plans and supporting people in this move back to the community are better able to ensure they cater for the needs of each person.

Who has been asked to be part of this research?

A range of people are invited to be part of the research to ensure a full picture of this move is gathered. The following people will be invited and each has been given an information sheet

- All patients who have recently moved to live fulltime in the community (in the last 12 months) from any of the inpatient units (you will not necessarily been involved in the care of any of these participants).
- Staff who are involved in planning and/or supporting patients in the move to the community and while living in the community.

Your decision to be part of this research is completely voluntary.

What does this mean for you?

The potential benefits that will occur from this research will primarily be about ensuring that new transition plans being developed in the future will take into account the needs of each individual.

If participating in this research brings up concerns for you that you need to speak with some one about then you are encouraged to contact the researcher on the contact details below.

What will participants be asked to do?

Should you agree to take part in this project you will be asked to participate in one face-to-face interview.

1. The interview will be done by sitting down and talking to you, for about an hour. This interview will occur in a room that is comfortable for you, such as an interview room of the service you are currently working in or a room in the main administrative building of the service. Questions about your experience of developing plans and/or supporting patients moving out of hospital and/or supporting patients while in the community will be asked. The questions will focus on what you did and what your experience was. The interview will not relate to one specific patient but you may find you use examples of your work with patients during the interview.

Personal information collected will be kept to a minimum and will relate to the length of time you have been employed within the service, length of time you have been involved with the developing of transition plans or supporting patients to return to the community, your gender, age range and ethnicity.

You will be able to stop at anytime, not answer questions or change your answers if you want to during any of the interviews. The interview will be recorded using a voice recorder.

Who will have access to the data and where will it be stored?

Two people will have access to this data in its raw form: The researchers below, and for a limited time, a transcriber employed by them.

The results of the project may be published and will be available in the University of Otago library but every attempt will be made to preserve your confidentiality. You are most welcome to request a copy of the results of the project should you wish.

The data collected will be securely stored in such a way that only those mentioned below and the transcriber will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for at least ten years, after which it will be destroyed.

How will your confidentiality be protected?

So that you feel comfortable in answering the questions as you want I promise to ensure the things you say during the interviews will remain private. Your answers will not be shared with other members of your team or other participants of the research. If you mentioned the names of any patients you work with during the interview their names and any identifying features will be changed to ensure their safety too.

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Your privacy will be protected except where your own safety or that of someone else is at risk.

Can I change my mind and withdraw from the project?

You can decide not to participate. You won't have to explain and nothing will happen because you decide not to participate. If you choose to be involved, you can change your mind and stop participating in the project at any time, without having to give any reasons. You can also withdraw any information that has already been supplied until two weeks after the interview has been completed.

You can refuse to answer any particular question, and ask for the voice recorder to be turned off at any stage.

Any questions?

If you have any questions now or in the future, please feel free to contact either:

Name: Penelope Kinney Position: PhD Student Department: Sociology Contact phone number: Ph. 03 479 6186 or 0800 762 786 ext 8186 Email: kinpe190@student.otago.ac.nz	Name: Anita Gibbs Position: Associate Professor Department: Sociology Email: Anita.Gibbs@otago.ac.nz
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This study has been approved by the University of Otago Human Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



Forensic patents transitioning to the community

Participant Consent Form for Staff of the service

Name of participant:.....

1. I have read the Information Sheet concerning this study and understand the aims of this research project. I have had sufficient time to talk with other people of my choice about participating in the study.
2. All my questions about the project have been answered to my satisfaction, and I understand that I am free to request further information at any stage.
3. I know that my participation in the project is entirely voluntary, and that I am free to withdraw from the project at any time without disadvantage. I know that I am free to ask for the voice recorder to be stopped for a period of time and be restarted only if I wish.
4. I know that the interviews will explore forensic psychiatric patients' move to the community and that if the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) , and /or may withdraw from the project without disadvantage of any kind.
5. I know that when the project is completed all personal identifying information will be removed from the paper records and electronic files which represent the data from the project, and that these will be placed in secure storage and kept for at least ten years.
6. I understand that the results of the project may be published and be available in the University of Otago Library, and that any personal identifying information will remain confidential between myself and the researchers during the study, and will not appear in any spoken or written report of the study.

Signature of participant:

Date:

PETER

Peter is a male in his late thirties. He has been in hospital between five to ten years and is detained as a Special Patient under the Criminal Procedures Mentally Impaired Persons (CPMIP) Act (chapter two provides an overview of this legislation). His transition to the community was through the forensic NGO. Peter was interviewed three times for the project, initially at his shared flat at the forensic NGO, the walking interview occurred around the suburb where the forensic NGO is situated and then finally back at his shared flat at the forensic NGO. Due to his Special Patient status Peter was subject to a range of conditions that influenced and impacted on his transition. At the beginning of the project Peter was still returning to the open rehabilitation ward one night a week, as part of his requirements for his Special Patient status. As the research progressed, but after Peters final interview, Peter moved to an independent flat in the community which he shared with his same flatmate from the forensic NGO. Peter started spending a night at the forensic NGO over twelve months ago and he gradually increased his nights till they were at six nights a week over a period of five to six months. He remained at that level for another six months and had now moved to seven nights a week. Peter receives support from both his forensic psychiatric clinical team and community support workers at his flat but he no longer has staff on site. Peter remained under the Special Patient status for the duration of the research.

Peter advised during his interviews his engagement with his transition had changed and progressed over the time he was at the forensic NGO. Initially he reported he was resistant to the suggestions and encouragement from his case workers. He did not want to follow through on their suggestions on finding work, preparing his curriculum vitae or completing the ward programme or groups. He was more interested in spending time doing the activities he wanted. Peter advised these thoughts have now changed. He sees the benefits of the range of activities he was “made to do”. Peter could now see how the groups that he did complete on violence prevention, living skills, communication and drug and alcohol were all useful to living in the community. He now willingly engages in activities and actively is looking for permanent work. Peter advised during the interviews he needs to be working to keep himself well, it was an important component for his wellness. Peter also advised he believed his admission into the forensic psychiatric service was hugely beneficial for him, though this was not

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what he believed initially. He believed he would be in prison or worse if he had not been admitted to hospital.

Peter fully engaged in the interviews. Each time he was interviewed at his flat at the forensic NGO he offered coffee to myself. He was keen to share a hot drink before the interviews began. This gave us an opportunity to informally chat and get ourselves settled, it allowed time for Peters flatmate to head out before the interviews started. Peter fully engaged in the interviews, taking time to consider his answers before providing them. Peter would at times pause before providing his answers however it was clear from his face he was considering what he would answer. Peter would spontaneously ask for clarification to questions if he did not initially understand them. For his walking interview Peter had initially suggested walking at the beach. Though when the time for his walking interview came about the weather was unsettled and Peter requested an earlier time and a change in location. He wanted to change to walking close to where he was living as he was having difficulty affording the petrol he would need to drive to the beach. When asked on the walking interview about the significance of the beach Peter advised he did not usually go to the beach but had suggested it as he had thought it was a place I would like to see. It was during the walk around Peters local suburb that Peter was able to pick out houses he liked and advised he wanted to live in similar situations in his future. He saw them as being in a safe area with minimal criminal activity occurring because they had shoes and other personal items out on porches and they were not being stolen. He also like them because they appeared to be in an area where the occupants could afford to maintain their property, gardens were well maintained and lawns were neat and tidy. It was important for Peter to be able to live in an area he could afford.

SEBASTIAN

Sebastian is a male in his early forties. He has been in hospital for ten plus years. Sebastian is detained as a Special Patient under the Criminal Procedures Mentally Impaired Persons (CPMIP) Act. His transition to the community was through the forensic NGO. Sebastian was interviewed three times for the project, initially at the open rehabilitation ward, the walking interview occurred at the local gardens and is situated within the central business district and then finally at his flat at the forensic NGO. Due to his Special Patient status Sebastian, similarly to Peter, was subject to a range of conditions that influenced and impacted on his transition. At the beginning of

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the project Sebastian was spending four nights a week at the forensic NGO and due to his work commitments the first interview occurred at the open rehabilitation ward because he spent his days off on the ward. By the time Sebastian participated in the third interview he was at the forensic NGO six nights a week so the final interview was held at his flat. This was Sebastian's second attempt at transitioning to the community. He had initially been transitioned into a shared flat situation. Unfortunately, the move had not gone well. His then flatmate was not under the forensic psychiatric service and the flatmate had given drugs to Sebastian without his knowledge and Sebastian had not responded well to these. As a consequence, Sebastian needed to be returned to the hospital until he had stabilised again. The decision by the clinical team was to now transition him to a flat by himself within the forensic NGO. Sebastian had commenced his second transition 15 months ago and by the end of the interviewing stage Sebastian had progressed to being six nights at the forensic NGO. Sebastian remained under the Special Patient Status during the research.

Sebastian held down part time work for the duration of the research. He worked three full days a week and enjoyed the opportunity to be engaged in the work force. Sebastian had secured work while in hospital and anticipated it continuing for the foreseeable future. He reported his boss was familiar with mental illness and this was helpful as he was supportive of him while at work. Sebastian was an active member of the local community; he was involved in a range of activities which required him to be engaging with the public. He was an active church member, he had joined a local community group which helped provide financial support for members of the local community so fund raising was a priority and helped educate health students on mental illness. Sebastian enjoyed socialising with people and reported being confident with engaging with people. Sebastian's main area of concern was about managing the maintenance of his flat along with cooking. He needed support with managing to complete all these tasks over the course of his day and week. Sebastian had been in hospital for a significant period so everyday general cleaning and maintenance activities like cleaning the toilet and mopping floors were unfamiliar to him. When he initially started spending time at the forensic NGO he needed the staff from the organisation not only to prompt him to complete these tasks but also to show him how to do them. In hospital these tasks were not completed by the clients so they did not have opportunities to practice them. The staff at the forensic NGO had developed a checklist with him to use as a prompt so he could ensure he completed all the necessary

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cleaning tasks. Over the course of the research Sebastian become more and more confident in completing these tasks independently and it was in his third interview he stopped the interview with me to allow him to go to his bedroom to collect his checklist to show me how he was now able to tick each activity off as he did them rather than needing staff to do this. Sebastian was very proud of this achievement and recognised it as real progression in his transition.

Sebastian participated fully in the range of interviews. He was keen to please and wanted to contribute in each of the interviews. Sebastian did have difficulties at times answering questions. For example, when asked what needed to occur for him to move out of the forensic NGO he was unable to answer this question. He advised he did not know; he just knew that he was not yet ready to do that. There were a number of times during his interviews that Sebastian would just repeat his answer to a question when he was asked for clarification about his previous answer. Sebastian selected the local gardens as the place he wanted to complete his walking interview. When asked how the gardens were important to his transition this question was difficult for Sebastian to answer. He enjoyed wandering around the paths in the sun and smelling the flowers. Sebastian's future plans included living in his own flat and to one day own a dog again.

HARRY

Harry is a male in his mid-forties. He has been in a combination of hospital and prison for almost 20 years. Harry is currently a sentenced prisoner and as a result is detained as a Special Patient. Harry was currently an inpatient at the open rehabilitation ward though the clinical team had commenced his transition programme to the community. He was not yet able to be unescorted in the community but was regularly entering the community with supervision from staff. He had unescorted leave from the ward to walk in the hospital grounds only. During the research project Harry was waiting for his parole hearing to occur and was anticipating this would be successful as he had the support of his clinical team. He also anticipated once his parole was granted the clinical team would commence his transition to supported accommodation similar to that of the forensic NGO however it was managed by corrections staff. Harry's two face to face interviews were completed in the visitor's room of the open rehabilitation ward and Harry's walking interview occurred in the hospital grounds.

Harry engaged in a range of activities in the community with the clinical team's supervision. He attended an internet café to learn about using computers, he helped

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with the ward shopping, he had completed voluntary work breaking down old computers until the work ended. Harry reported anxiety was significant for him when trying new things and he was working closely with the clinical psychologist and other professionals to develop appropriate coping strategies to manage his anxiety. Mindfulness and breathing activities were strategies he used successfully.

Harry was mindful of his parents ages and was hoping he would be able to support them like they were supporting him in the future. Harry was no longer in the geographical area where he had spent his life prior to his offence, his parents had elected to move to be closer to him and so had moved away from his birth place. Due to the nature of his offence Harry knew it was not going to be possible for him to return to his original place of birth and he was resigned to that, though he still missed it. He wanted to be able to provide for his parents and to be as supportive to them as they were to him. Harry was also aware that he would be subject to lifetime parole conditions and that he must adhere to all those requirements if he was going to live in the community. He would be monitored for the rest of his life and this would influence where he would finally live.

Harry reports being fully engaged with the ward programme. He has participated in a range of groups which aims to support him with his eventual transition to the community, such as social skills, communication etc. Harry has had his progression stalled due to decisions he has made in the past. He reported he had smoked tobacco on hospital grounds (hospital grounds are non-smoking) and consumed legal highs, and got another client to complete the urine test for him. These actions saw him return to the secure ward and then have his transition start again. Harry's focus was to "keep his nose clean" for the future so not to jeopardise his transition again.

Harry actively participated in all the interviews, often giving in-depth answers to questions and providing more depth when asked. Harry was only able to walk in the hospital grounds due to his conditions, however he was able to describe how these regular walks were important to him and his transition out of the hospital. He was hopeful he would soon achieve unescorted leave into the community.

It was after the data collection had finished and I was returning to the open rehabilitation ward to meet with staff about the project did I learn that Harry was not successful with his parole and due to bed requirements and because Harry was deemed as being mentally settled he was return to prison to finish his sentence. At this point

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Harry would not be transitioning to the community from the forensic psychiatric service.

JOE

Joe is a male in his mid-forties. He has been in hospital ten plus years. Joe is detained as a Special Patient under the Criminal Procedures Mentally Impaired Persons (CPMIP) Act. His transition to the community was through the forensic NGO. Joe was interviewed three times for the project, initially at his shared flat at the forensic NGO, the walking interview occurred around the central business district of the city in which he lives and then finally back at his shared flat at the forensic NGO. Due to his Special Patient status Joe, similarly to Harry and Sebastian, was subject to a range of conditions that influence and impact on his transition. At the beginning of the project Joe was still returning to the open rehabilitation ward one night a week, as part of his requirements for his Special Patient status. As the research progressed, but after Joe's final interview, Joe moved to an independent flat in the community which he shared with his same flatmate from the forensic NGO. Joe started spending a night at the forensic NGO over fifteen months ago and he gradually increased his nights till they were at six nights a week over a period of three to four months. He remained at that level for another twelve months and had now moved to seven nights a week. Joe receives support from both his forensic psychiatric clinical team and community support workers at his flat but he no longer has staff on site. Joe remained under the Special Patient status for the duration of the research.

Joe was happy to engage in all three interviews. He initially appeared apprehensive when the first interview occurred however he relaxed and was spontaneously smiling and joking with me during the interviews. Joe was very positive about leaving hospital and eventually living full time in the community. He believed he had spent significant time in hospital already due to the amount he had disclosed to his clinical team over the years. He believed this had a detrimental effect on the length of time he had been in hospital. Joe appeared proud of all the groups he had been involved in during the course of his transition. He believed these had helped him in his success to date. Joe preferred to limit the amount of activities he was involved with during his day. He did not enjoy feeling as though he was very busy and found it a fine line between relaxing and being bored. Joe was not actively looking for paid employment because he did not believe he was ready for this. He had in the past held employment but found this to be

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detrimental to his mental health. He reported he had become paranoid in the past and became suspicious of his boss, as a result he was not able to maintain the work he had to complete and he was unable to hold onto his job.

Joe spoke of his significant criminal activity in the past. He spoke of his time in Mt Eden prison and how he is constantly aware of how easy it would be to go back to this old way of life. Joe is determined not to return to this and is confident of his ability to keep away from crime. Joe spends significant time with his mother and wants to be there for her as it is time to reciprocate the support she has provided in the past. During the course of the research Joe had successfully completed his car licence. He had achieved his restricted licence and by the third interview Joe had achieved his full licence. This was a significant milestone for Joe as he had never driven legally before and his pride in his achievement was evident in how he spoke and held himself. Joe had been an avid user of the bus service, this had surprised him as he had previously viewed the bus as something only poor people used, however during his transition he became familiar with the bus routes and the buses provided him with independence. Since gaining his car licence and purchased a car he no longer used the buses.

Joe took me to the educational institute he attends twice weekly for his walking interview. We followed his usual route at the usual time he goes. He was keen to show me around the building and to talk about the literacy and numeracy education he is doing. He views these courses as opportunities for him to improve himself. It was important he increased these skills for his future. It was during his third interview he advised he had ceased attending this institution. He had been frightened the whole time he had attended because of its location and the number of stories he had to go up. His anxiety had been significant; however, it had taken him quite a bit of time to convince his clinical team he should no longer attend. When asked, he advised he did not believe the clinical team was happy, however, he has now registered to attend similar courses at a different institution. This one is single story so he did not believe there would be any issue for the future. Joe was looking forward to sharing a flat in the community away from the forensic NGO and to one day find work, however it was not a priority yet. He had indicated he was interested in becoming a car sales man however his clinical staff had discouraged this because of his Special Patient status and it would not be a good look.

SMELLY

Smelly is a male in his early forties. He has been in hospital approximately seven years. Smelly is detained under the Criminal Procedures Mentally Impaired Persons (CPMIP) Act but is not a Special Patient. This means decisions around his transition can be made without gaining a range of approvals from different overseeing panels. The clinical team was able to make decisions quickly. Smelly had started transitioning to his accommodation three months before his first interview.

Smelly's transition to the community was through an alternative supported accommodation which was viewed as a long term care unit and had similar support to a rest home. Smelly was interviewed three times for the project, initially at the open rehabilitation ward, the walking interview occurred on the hospital grounds and finally at the open rehabilitation ward. At the first interview Smelly was spending one night a week at the accommodation he was transitioning to and by the third interview he was spending five nights a week. Smelly had eventually moved to living permanently at the accommodation after his final interview but before the project had finished.

Smelly's interviews were stilted much of the time because his ability to engage in spontaneous conversation was limited. Smelly had a delay of up to 20 seconds after he was asked a question and this was because he was struggling to process the question rather than trying to formulate his answer. Smelly appeared to be significantly impacted by a condition known as poverty of thought or poverty of speech (American Psychiatric Association, 2013). Much of Smelly's answers were either single words or were only short sentences.

Smelly was focused and concerned about his morbid preoccupations (where he believes he must kill the person in front of him) and how they will impact on his transition to the community. Smelly had a range of strategies he utilised to manage these as they came up. I had been forewarned by the clinical staff about his preoccupations. Though I was no longer a staff member I gained access to clinical information not normally shared with outsiders. I believe this was because of my past employment in the service and my personal knowledge of the staff on site. As a result I had strategies to manage the preoccupations if they presented themselves during the interviews, they did not.

Smelly had moved to accommodation where managing usual household activities like cooking and cleaning were not expected from him. He was happy with this and had no

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interest in completing these. He viewed he would have more time to work on his computer programming. Smelly was very focused on his computer and the programme that he is writing. He advised he would like to one-day work for a computer company however some staff did not believe this was likely or achievable.

I accompanied Smelly on his walking interview around the hospital grounds. The walk was literally around the boundaries of the grounds. Smelly chose to walk on muddy grass rather than walking on the pavement because the pavement was outside of the boundary. The clients are very aware of members of the public watching to catch them out and to pass this onto the media. The result would be detrimental to their transition. Smelly also chose to walk between cars and the fence because that was where the boundary was, even though there was very little room for a person to get through. He appeared very concrete and literal in his thinking and this flowed into his actions.

Smelly enjoyed regular contact with his family. He walked weekly around the grounds with his mother and his father and other family members would visit periodically. He advised he enjoyed these opportunities as he caught up with what his family was doing. Staff had advised myself his family had permission to take Smelly off the grounds when they visited, however, they chose not to. Staff were unsure why this was but believed it was because the family was anxious about what to do if Smelly's preoccupations became apparent while he was with them and away from the ward. Smelly lives fulltime at his new accommodation and does not plan to move on from there in the future.

JAE

Jae is a male in his late twenties. He has been in hospital for over five years. When I met him he was living fulltime at the forensic NGO. Though he is overseen by the forensic psychiatric service he is not a Special Patient so does not have all the conditions that the other clients do. Jae has been living at the forensic NGO for over twelve months. It took him one month to move from the open rehabilitation ward to the forensic NGO.

Jae participated in only one interview. Jae's interview was similar to Smelly, he had difficulty staying focused on the topic and he would flit from one topic to another. Jae was bright and bubbly during my interview with him however he struggled to remain focused on what the interview was about. At times his answers were in single words or

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short sentences. Jae became unwell during the research and though he was initially happy for me to approach him again for future interviews when I checked in with staff they suggested waiting until he settled again. Unfortunately, Jae did not settle in the time frame of the research.

Staff believed one of the major contributing factors for him becoming unwell was confusion about funding and that he had lost funding for the range of activities he participated in, which helped keep him well. Clients under the specific forensic psychiatric funding were eligible for something known as flexi funding. This then was used to cover bus fares and other activities costs. However, Jae was moved out of the specific forensic funding and into the general mental health funding (though he remained in the same flat at the forensic NGO and remained overseen by the forensic psychiatric service). This cause real confusion for Jae and he was unable to understand why he could no longer access funding and why he was now required to pay for these things himself.

When the research was completed Jae was still at the forensic NGO and was now transferred back to the specific funding for the forensic psychiatric clients, however he was not settling and staff were unsure if he would remain at the forensic NGO as he was now re-engaging with illicit drugs and alcohol and had assaulted a member of the public and had been charged.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Publishing.

Appendix P

INTERVIEW GUIDE – CLIENT PARTICIPANT

The following are prompt questions I will use when interviewing client participants during the research, further prompting questions may required at times, such as “what do you mean by that?” or “would you give me an example?”.

I have divided the interview guide into the three different interviews that will be completed with the client participants.

Demographic material will be collected prior to commencing the first interview which includes:

Age range

Gender

Ethnicity

Length of time in hospital

Length of time you spent moving to the community

Length of time since living fulltime in the community

Interview One – Initial meeting interview (Community and Inpatient)

- 1) Tell me about your move to the community
- 2) What happened/is happening during your move to the community?
- 3) How would you best describe what happened?
- 4) What do you really enjoy doing while in the community?
- 5) What do you think helped you move to the community?
- 6) What do you think made your move to the community difficult or challenging?
- 7) What do you think would have made your move the to community easier?
- 8) How do you find living fulltime in the community? (community only)
- 9) How do you find the process of moving to the community?
- 10) How did/do you feel about moving to the community?
- 11) Who do you spend time with while in the community?

Interview Two – Walking Interview

Prior to commencing the walking interview the client participant will be reminded a camera is available to take photos of areas that are important now or were important during their move to the community. The camera will be held by the researcher and no photos of people will be taken. The following are prompts to be used while walking around the geographical location.

- 1) Tell me about this area we are walking in?
- 2) How is it important to you?
- 3) How was it important during your move to the community?
- 4) How is it important now?
- 5) If you could change one thing about this area what would it be?
- 6) Would you explain why you chose that thing?
- 7) What would be one thing you would not like to see change about this place?
- 8) Why did you chose that thing?
- 9) Do you spend time with other people in this area?

Appendix P

Interview Three – Use of photo prompts

The final interview will be an opportunity to check with the client participant the initial coding from interview one and two and to use the photo's taken during interview two to elicit further information on the transition process undertaken.

- 1) Please select a photo you would like to talk about.
- 2) Why have you chosen this photo first?
- 3) Would you tell me why the subject of this photo is important to you?
- 4) How was it important to your move to the community
- 5) How did it impact on your transition to the community?
- 6) How is this important to you now?
- 7) Do you spend time with other people here?
- 8) What do you remember of this place?

INTERVIEW GUIDE – STAFF PARTICIPANT

The following are prompting questions I will use when interviewing staff participants during the research, further prompting questions may required at times, such as “what do you mean by that?” or “can you give me an example?”.

Age range

Gender

Ethnicity

Length of time employed within the service

Length of time you have been involved with developing transition plans or supporting clients move to the community

or

Length of time you have been involved in supporting clients in the community

- Would you tell me about the role you take when either developing transition plans or supporting clients in the community?
- What things do you see as important to consider when developing transition plans?
- What do you notice about the behaviour of clients during this transition time?
- What do you notice about the thought processes of clients during this time?
- What do you see as important things that help a client successfully move to the community?
- What do you see as things that negatively impact on a client’s successful move to the community?
- How do you see clients interacting with others in the community during the transition time?
- Are there particular activities that are helpful when clients are moving or living in the community?
- What factors determine if a transition to the community is successful?

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- What does a successful transition to the community look like?
- What changes, if any do you notice in the behaviours of the person transitioning to the community?
- Do you see any changes during the time you are supporting them?

INITIAL CODING EXAMPLES

Peter – Client Participant

Initial Codes	Transcript
<p>Looking for options</p> <p>Starting qualifications,</p> <p>Getting educated,</p> <p>Preferring a painting apprenticeship</p> <p>Knowing dislikes,</p>	<p>Interviewer: So tell me about that? #0:12:57.9#</p> <p>Peter: Arrr, I've got three pre-trade certs from [Polytechnic], painting and decorating, umm, welding and painting, I mean plumbing gas fitting and drain laying. But I'm looking for an apprenticeship in painting and decorating cause I didn't really like the welding and the gas fitting, too much digging holes and sawing stuff. Yeah#0:13:21.4#</p>

Taylor – Staff Participant

Initial Codes	Transcript
<p>Stretching the rubber band</p> <p>Working at their stage</p> <p>Ensuring feelings of comfort</p>	<p>Interviewer: What kind of things do you see as important to help people transition to the community? #00:06:21.10#</p> <p>Taylor: To get their trust, and to work at their pace, umm, but also you've got to be able to stretch that rubber band a bit, you know, you've got to be able to, to get them to feel comfortable taking that extra step. #00:06:44.58#</p>

Appendix S

H14/139



Academic Services
Manager, Academic Committees, Mr Gary Witte

3 October 2016

Assoc. Prof. A Gibbs
Department of Sociology, Gender and Social Work

Dear Assoc. Prof. Gibbs,

I am again writing to you concerning your proposal entitled **“Exploring the transition process of moving from hospital to the community within a regional forensic psychiatric service in Aotearoa/New Zealand”**, Ethics Committee reference number

Thank you to Penelope Kinney for her email of 29th September 2016 requesting an amendment to the above study. It is noted that you would like to add a reference group to review the themes and sub-themes identified in the data. Thank you for noting that the panel will not have direct access to any of the participants interview recordings or transcripts.

The committee accepts and approves the amendment.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
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c.c. Assoc. Prof. C Brickell Department of Sociology, Gender and Social Work